Alabama Medicaid Agency

Regional Care Organization (RCO) Frequently Asked Questions (FAQs)

As of November 10th, 2016

Health Home Program	
Date Added/ Revised	**Questions and Answers**
1/21/15	**Q1. What is the Health Home program?** A1. The Health Home program is defined by the federal government as an optional Medicaid program that integrates and coordinates care for recipient with certain chronic conditions to achieve improved health outcomes. In Alabama, the Health Home program is set up to add an additional level of support to Patient 1st Primary Medical Providers (PMPs) by intensively coordinating the care of recipients who have or are at risk of having certain chronic conditions: asthma, diabetes, cancer, COPD, HIV, mental health conditions, substance use disorders, transplants, sickle cell, BMI over 25, heart disease, and Hepatitis C. Case Management, or coordinate care in the Health Home program is done by connecting recipients with needed resources, teaching self-management skills, providing transitional care, and bridging medical and behavioral services, among other services. The Health Home program was first implemented in Alabama in 2012 as a pilot project in four areas of the state, known as Patient Care Networks. On April 1, 2015, the Health Home program will be expanded statewide and managed by probationary RCOs who submit qualifying proposals for their respective regions. By allowing probationary RCOs that are working toward full certification to first operate the Health Home program, these organizations will demonstrate that they have resources to manage recipients in their region prior to taking on full risk.

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1/21/15	**Q2. What does it mean if providers do not join the Health Home program? Will providers lose their Medicaid recipients or be paid less?** A2. Alabama Medicaid will continue to operate its current fee-for-service program until full-risk RCOs are implemented in October 2016. PMPs will not lose recipients from their Patient 1st panels when Medicaid's Health Home program goes statewide on April 1, 2015. The case management fees paid to PMPs in the expanded counties will change. Patient 1st PMPs who contract with a probationary RCO that is operating a Health Home program will receive an additional 50 cents per month, per recipient assigned to their panel and an additional $8 per recipient, per month, for each assigned recipient with a qualifying chronic condition(s) (FQHCs and Rural Health Clinics are excluded). If a Patient 1st provider does not contract with a probationary RCO that is operating a Health Home program, they will receive 50 cents per recipient, per month for all recipients in their panel. More information on this may be found in Medicaid Provider Manual Chapter 39.4 and Attachment B of the Patient 1st Enrollment Form, both found on the Agency's website www.medicaid.alabama.gov under Contact > Provider Enrollment > Forms > Administrative Forms
1/21/15	**Q3. What is a panel size?** A3. Panel size represents the number of recipients assigned to a Patient 1st PMP. Specialists do not have assigned recipients. Generally, PMPs may have up to 1,200 recipients although that may be increased up to 2,000 if physician extenders (limit of two) are employed within the practice.
1/21/15	**Q4. How does the Health Home program affect a provider's current Patient 1st panel?** A4. Implementation of the Health Home program will not change a PMP's current panel. Patient 1st recipients will continue to have the ability to choose the doctor or clinic for their PMP and change PMPs as is presently done.
1/21/15	**Q5. Do PMPs have to take on more Medicaid recipients if they participate in the Health Home program?** A5. No. PMPs determine the number of recipients they will accept in their panel.
1/21/15	**Q6. Do PMPs need to have an agreement with RCOs in other regions if they refer recipients to providers in other regions?** A6. No. Your ability to refer recipients will not change under the Health Home program.
1/21/15	**Q7. Are Medicaid providers responsible for making the initial contact to discuss being included in the network(s) or will the RCOs be contacting providers?** A7. Probationary RCOs will contact providers as part of the process to demonstrate that they have an adequate provider network. However, providers are welcome to contact the probationary RCOs as well. A list of contacts is on the agency's website at www.medicaid.alabama.gov under Newsroom > Regional Care Organizations

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1/21/15	**Q8. If there is more than one Health Home program in a region, are providers obligated to join more than one?** A8. No. The decision to sign a LOI or contract with any RCO organization is up to the provider.
1/21/15	**Q9. Are recipients in the Health Home program "homebound" that receive Home Health services and not come to doctor visits?** A9. The Health Home program is not to be confused with home health services. Recipients who receive case management services through the Health Home program are Patient 1st recipient with specific chronic conditions. They are typically ambulatory recipients.
1/21/15	**Q10. What are RCOs?** A10. Regional Care Organizations (RCOs) are locally- led managed care systems that will ultimately provide healthcare services to Medicaid recipients covered under the 1115 waiver at an established cost under the supervision and approval of the Alabama Medicaid Agency. RCOs were created by state law in 2013. As of January 1, 2015, 11 organizations have been awarded probationary certification by the state, allowing them to work toward full implementation by October 1, 2016. More information is available on Medicaid's website at www.medicaid.alabama.gov under Newsroom > Regional Care Organizations.
1/21/15	**Q11. What is the difference between the Health Home program and RCOs?** A11. Regional Care Organizations (RCOs) are locally- led managed care systems that will ultimately provide healthcare services to Medicaid recipients at an established cost under the supervision and approval of the Alabama Medicaid Agency. As of April 1, 2016 only probation organizations will be allowed to operate the Health Home program. These same organizations will continue to demonstrate their ability to take on full risk and operate the full set of services and benefits on October 1, 2016. The Health Home program is focused on the enhanced care management function; whereas under the full RCO program, these organizations will assume full risk of their covered population. The Health Home program is an interim step designed as a building block for probationary RCOs that are working toward full certification by facilitating network development and providing resources while offering the probationary RCOs an opportunity to demonstrate that they have resources to manage recipients in their region.

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1/21/15	**Q12. What region am I in?** A12. Five regions have been set up as required by state law. Recipients are mapped based on their address. Providers may participate in multiple regions. The map will be used for both the Health Home program (starting April 1, 2015) and the planned Regional Care Organizations in October 2016. The map was drawn with input from providers, Medicaid recipients and others and is designed to recognize existing referral patterns and to keep various health systems together when possible. A copy of the map is available on the agency's website www.medicaid.alabama.gov under Newsroom > Regional Care Organizations.
10/7/14	**Q13. Will AMA consider adjusting the Health Home program's educational requirements for case management workers (BSN v. LPN) as it could cost more money?** A13. The Agency will not adjust this requirement.
2/26/15	**Q14. Do the RCOs only deal with patient health homes? Or will all Medicaid claims need to go through RCOs?** A14. Beginning April 1, 2015, qualifying probationary RCOs will operate Health Home programs in their respective regions. On October 1, 2016, the Health Home program will be folded into the full-risk RCO program. At that time, claims for covered services provided to Medicaid recipients in the RCO program will be filed to the RCOs for payment. Claims for services provided to Medicaid recipients outside of the RCO system (e.g. foster child) will be filed as usual to Medicaid through HP on a fee-for-service basis.
5/15/15	**Q15. What if some of my patients choose not to participate in the Health Home but are still in the Patient 1st Program in the next one or two years?** A15. The decision to receive health home services is up to the recipient. There is no penalty if health home services are declined. The recipient will continue to receive Medicaid covered services via his or his Patient 1st PMP.
5/15/15	**Q16. What does it mean when recipients of a non-contracted provider may have to receive "Health Home services" from another provider?** A16. If a qualifying recipient desires to receive the extra services available through the Health Home program, but his or her PMP declines to contract with a Health Home program, the patient will continue to get Medicaid covered services, but cannot receive enhanced case management services available via the Health Home program. If the recipient desires these services, it will be necessary for the recipient to change to a Patient 1st PMP who has contracted with a Health Home program.

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1/21/15	**Q17. What is a LOI? What is the purpose of the LOI?** A17. A LOI is a non-binding Letter of Intent between a probation RCO and a provider which indicated a provider's intent to contract with that particular organization. Probationary RCOs that plan to operate a Health Home program starting April 1, 2015, must submit signed LOIs for Primary Medical Providers (PMPs) to Medicaid by February 11, 2015, to demonstrate that they have an adequate provider network for the Health Home program. Probationary RCOs are also required to provide signed LOIs to the Alabama Medicaid Agency by April 1, 2015, to demonstrate that they have an adequate provider network. For this requirement, primary medical providers, facilities and core specialists as described in an Alabama Medicaid Agency ALERT issues on January 7, 2015, are asked to sign a LOI as an expression of their interest. Providers may sign LOIs at any time for the RCO Program.
1/21/15	**Q18. Is the LOI with the Alabama Medicaid Agency or the RCO?** A18. A LOI is a non-binding Letter of Intent between a probationary RCO and a provider which indicated a provider's intent to contract with that particular organization. It is the responsibility of the Probationary RCO to contact providers to obtain a signed LOI. Providers may also contact the RCO directly. A list of approved probationary RCOs is available on the agency's website at www.medicaid.alabama.gov under Newsroom > Regional Care Organizations.
1/21/15	**Q19. Which organization should providers sign LOIs with?** A19. Providers are free to sign an LOI and ultimately contract with one or more RCOs both within and outside the region in which they are physically located. Primary Medical Providers may want to sign with RCOs in regions where their recipients live as RCO assignment will be based on the residence of the Medicaid recipient. Core specialists and hospitals likewise may want to consider with RCOs in other regions if their recipient service area covers multiple regions.
2/13/15	**Q20. Is a letter of intent required for the providers and Nurse Practitioners?** A20. The LOI under the clinic's name would need to include each individual provider's and nurse practitioner's NPI number.
2/13/15	**Q21. Can provider groups be listed on one LOI?** A21. Provider Groups can include all providers on one form with the individual NPI numbers but will also need to include an LOI form for each RCO they elect to participate in.
2/13/15	**Q22. Is an LOI required for each specialty?** A22. The LOI under the clinic's name would need to include each individual provider's NPI number.

Health Home Program	
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6/3/15	**Q23. We are a large group of Eye and ENT physicians (36 providers). We have 5 different locations all using the same NPI and Tax ID. Can you providers be listed on one LOI signed by our CEO?** A23. Provider Groups can include all providers on one form with individual NPI numbers but will also need to complete an LOI form for each RCO they elect to participate in.
3/19/15	**Q24. Are facility providers (I represent DaVita, a dialysis provider) required to sign an LOI with RCOs? We have been approached by 2 RCOs access all 5 regions, requesting us to sign an LOI. Although we are interested in partnering with RCOs and serving AL Medicaid patients, we do not sign LOIs. I understand that the timeline for RCOs to demonstrate preliminary network adequacy in core services is 4/1/15; however, the RCO requests have been very recent and it is unlikely that DaVita will be able to move that fast.** A24. Providers are free to sign a LOI and ultimately contract with one or more RCOs both within and outside the region in which they are physically located. However, in order to be reimbursed for RCO-contracted services on or after October 1, 2016, providers, including End Stage Renal Disease Treatment and Transplant Centers, must contract with one or more RCOs.
3/19/15	**Q25. Does AMA allow edits to the LOI template? Although it is our strong preference NOT to sign an LOI and move straight to contracting, if we were to sign an LOI we would like to include some statements around payment rates, but nothing that would alter the template language provided by AMA.** A25. Edits to the LOI template are not allowed. The LOI is a non-binding expression of interest between a probationary RCO and certain providers which indicates a provider's intent to contract with that particular organization. This information is used by the Agency to assess the adequacy of each probationary RCO's provider network.
4/14/15	**Q26. We do the billing for practices that only accept Medicaid as a secondary insurance. Do these providers still need to sign a LOI with the RCOs?** A26. Yes, the provider would need to sign a LOI if he/she falls into one of three categories: Primary Medical Provider, Certain Facilities or Core Specialist. See Medicaid ALERT dated 1/7/15 for a list of these providers. (http://medicaid.alabama.gov/news_detail.aspx?ID=9361) The only recipients with TPL that are excluded from the RCO are 1) the ones who have other managed care insurance and 2) those whom we pay the insurance premium through HIPP. All other recipients with TPL will be enrolled.

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4/22/15	**Q27. Our clinic has one MD and three nurse practitioners. Do we need to fill out a letter of intent for each MD and each NP or just one for the MD and list the NP's on the MD's letter?** A27. An LOI would only be required for the MD, not the NP.
4/22/15	**Q28. What about a letter of intent under the clinic's name?** A28. The LOI under the clinic's name would need to include each individual PMPs NPI number.
4/22/15	**Q29. We have received a letter of intent from the two contractors in Region 2. How do you know which contractor to choose, or is it better to fill out a letter of intent for each contractor for now?** A29. It is up to the Practice to contract with the RCOs. You may sign the LOI with any Probationary RCO that you choose.
6/3/15	**Q30. We are a large group of Eye and ENT physicians (36 providers). We have 5 different locations all using the same NPI and Tax ID. Can our providers be listed on one LOI signed by our CEO?** A30. Provider Groups can include all providers on one forms with individual NPI numbers but will also need to complete an LOI form for each RCO they elect to participate in.
5/15/15	**Q31. Can the Physician send the Practice Administrator in his place to the quarterly meeting? A quarterly meeting outside of the office will be a considerable expense to the physician between the travel expenses and then the loss of time from the office and his patients. It is crucial that we know what is expected of the physician before he signs the agreement.** A31. All participating Health Home providers must attend quarterly medical management meetings in person.
6/3/15	**Q32. I represent several large emergency room physician groups and hospitalists practicing in the State of Alabama (Districts B, D, and E). I understand that the Medicaid program is rollout out probationary RCOs in these Districts. I have been inundated with RCO Letters of Intent for the individual physicians to sign. My understanding is that individual hospital-based physicians are not required to sign Letters of Intent/participate at this time. If my understanding is correct, is there some type of Alert that could be sent out to the RCOs advising them that hospital-based physicians are not required to be part of their networks at this time?** A32. Only PMPs are required to sign Letters of Intent.

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	Q33. Will the Health Homes continue to need Provider Health Home Agreements if they are already contracted with the RCO? A33. If a Health Home provider agreement expires prior to the RCO contract, it will need to be renewed. Any agreement that expires after the RCO contract begins will not need to be renewed.

Benefits/Covered Services	
Date Added/ Revised	**Questions and Answers**
7/24/14	**Q34. Will RCOs provide the same benefits and covered services that are offered under the FFS program?** A34. At a minimum, RCOs will be required to provide the same level of covered benefits and services as provided under the FFS program. Enhanced benefits and covered services will be at the RCOs discretion subject to Medicaid approval, but will not be accounted for in the development of capitation rates.
7/24/14	**Q35. What happens when recipients move from one RCO area to another? If one RCO provided equipment or a service and their new RCO did not, what would happen?** A35. As long as the provider is contracted with the RCO, he or she can see recipients that are not on the panel. If the recipient is not eligible, the recipient can see any provider for fee-for-service. If the recipient is not assigned to a PMP but assigned to an RCO, the payment will come from the RCO – not the Medicaid Agency. If the provider is not contracted with the RCO and if the RCO network is unable to provide necessary services covered within the RCO program, the RCO will coordinate with the non-participating provider for payment. The cost to the recipient will not be greater than if the services were furnished in network.
7/24/14	**Q36. What requirements or restrictions would Medicaid allow RCOs to place on second opinions?** A36. More information will be forthcoming with the release of the finalized RCO contracts.
4/03/15	**Q37. How will the RCO affect DME Suppliers?** A37. DME will be covered by the RCOs. DME Providers will need to contract with RCOs to provide covered services to RCO enrollees after October 1, 2016. Claims for services provided to Medicaid recipients outside of the RCO system (e.g. foster child) will be filed as usual to Medicaid through HP on a fee-for-service basis.
4/03/15	**Q38. It is my understanding that DME items including lancets will not be covered as a "pharmacy item" but rather be paid under the RCO DME benefit. I am needing to verify how the strips will be handled.** A38. Testing strips (and lancets) are now considered to be a DME item and will be reimbursed by RCOs as an RCO-contracted service/supply. There is a rule regarding minimum FFS rates, see Rule No. 560-X-62-.10 Minimum Fee-For-Service Reimbursement Rates (http://medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3.5_Rules.aspx)

Benefits/Covered Services	
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4/03/15	**Q39. It is my understanding that infusion services billed through HCPCS (and through the DME provider NPI) will be included in the RCOs. Are infusion services provided on-site in an infusion suite at a specialty pharmacy location also part of the RCO system, or are they fee-for-service since they would not be considered a home infusion therapy service under DME Section 14.2.29 of the Alabama Medicaid Provider Manual?** A39. Infusion services billed through HCPCs are currently billed through the DME NPI, not the pharmacy NPI. The infusion services billed through the DME NPI will be an RCO-contracted service.
4/03/15	**Q40. Please advise as to actions that pharmacy DME providers will need to take to ensure they are included in networks for RCOs.** A40. At this time, the pharmacy program will not be an RCO-contracted service and will be operated by the state. DME Providers will eventually need to contract with one or more RCOs to be reimbursed for RCO-contracted services.
4/14/15	**Q41. Kid One Transport System has a strategic initiative to serve all 67 counties in Alabama from our current 40 county foot print. To accomplish this goal, we are working with the various RCO organizations in the state to offer our service as a resource to help them succeed. One of the issues our board is wrestling with "is it feasible and/or necessary for us to serve all 67 counties"? I wanted to ask for your help to provide us some information to help us make an informed decision about our service area.** **What are the number of non-emergency transports provided annually for Medicaid recipients by either carriers like Kid One Transport or paid directly to the Medicaid recipient?** **Are there counties that do not have carriers like Kid One Transport available or have a low number of services available for the Medicaid recipient?** A41. County data provided via spreadsheet containing most reliable information available.
4/14/15	**Q42. Of the number of non-emergency transports provided annually, how many are dental related?** A42. This information is not available.

Benefits/Covered Services	
Date Added/ Revised	**Questions and Answers**
5/15/15m	**Q43. Regarding medications: are all drugs (oral and physician-administered injectables) carved-out to the Medicaid fee-for-service program? Not the RCOs? If so, meaning carved-out of the RCO, is this indefinitely or for a set period of time?** **I assume there isn't any specific drug classes? For example, drugs for mental health use?** A43. Physician administered drugs will be covered under the RCOs. Pharmacy is carved-out indefinitely. NDC codes billed utilizing NCPDP standard transactions are excluded from the RCOs. Drugs which are injected or administered in a hospital, infusion suite, or physician's office and billed utilizing HCPCS codes on a medical or institutional claim, are included in the RCO.
6/3/15	**Q44. We received the Medicaid Alert letter last week. I am a bit confused, I did not see Dental Practices list on the back of the letter. You have PMPs, Facilities and Core Specialists. Dentistry isn't listed. Are we required to complete a letter of intent?** A44. Dentistry is currently carved out of the RCO program, therefore it is not necessary for you to submit a LOI.
12/01/15	**Q45. What if I don't like the doctors to choose from in my region?** A45. Under the Patient 1st program, recipients have the right to change Patient 1st doctors, but must choose a doctor who has agreed to see patients from the recipients' county and who has an opening. Beginning October of 2016, recipients will be given a choice of RCOs and will have an opportunity to select a primary care provider who has contracted with the RCO of their choice. Enrollees can choose from any of the primary care providers that have contracted with the RCO in the enrollee's region. If the desired provider is not within 50 mile radius or if other extenuating circumstances exist, the recipient will need to file an appeal with the RCO.

Benefits/Covered Services	
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12/07/15	**Q46. Will Blood Glucose Testing Strips remain covered by the Pharmacy program and be carved out of the RCO program, or if they will be transitioned to the RCO?** A46. Testing strips (and lancets) are now considered to be a DME item and will be reimbursed by RCOs as an RCO-contracted service/supply. There is a rule regarding minimum FFS rates, see Rule No. 560-X-62-.10 Minimum Fee-For-Service Reimbursement Rates (http://medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3.5_Rules.aspx)
6/6/16	**Q47. Is there a vision benefit for kids and for adults? Can you please explain what is available?** A47. Yes, the vision benefit is covered for kids and adults. If a Medicaid recipient requires eyeglasses, services include verification of prescription, dispensing of eyeglasses, frame selection, procurement of eyeglasses, and fitting and adjustment of the eyeglasses to the patient. Recipients 21 years of age and older are eligible for one pair of eyeglasses every three calendar years. Recipients under 21 years of age are authorized two pair of glasses each year if indicated by an examination. Medicaid may prior authorize additional eye exams and eyeglasses for recipients under 21 years of age and over 21 years of age only for medically necessary reasons such as eye injury, disease, unrepairable damage to glasses, or significant prescription change. These limitations also apply to fittings and adjustments.
6/6/16	**Q48. As the owner of a rural pediatric Therapy clinic I am confused about the RCO's. I currently provide services to children in 7 counties. How will therapy services be impacted? Specifically, wil there be limits on the number of visits? Will reimbursement of services be decreased?** A48. Physical therapy, occupational therapy, and speech therapy services will be covered by the RCOs. Providers will need to contract with RCOs to provide covered services to RCO enrollees after October 1, 2016. Claims for services provided to Medicaid recipients outside of the RCO system (e.g. foster child) will be filed as usual to Medicaid through HP on a fee-for-service basis. Any changes to limitations on the number of visits made by the RCOs must be approved by the Agency first. Reimbursement of services will only be decreased if the provider and RCO agree to this type of fee schedule.
6/6/16	**Q49. Is Occupational Therapy covered for acute conditions in a hospital outpatient setting for non-EPSDT recipients?** A49. Yes, Occupational Therapy for non-EPSDT recipients is covered for acute conditions in a hospital outpatient setting.

Benefits/Covered Services	
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6/6/16	**Q50. I have attended several RCO meetings and have noticed that I seem to be the only member of Emergency Medical Services in attendance. My question is where does EMS fit into the equation? And how will we be reimbursed for emergency calls, transport and/or treatment initiated by Medicaid Patient's and other agencies and or hospitals wishing to arrange transport for Medicaid patients?** A50. Emergency transportation is a covered benefit under the Alabama Medicaid program, and the RCOs are responsible for reimbursement of that benefit for their members. For reimbursement, EMS should contract with RCOs.
6/6/16	**Q51. We are provider of substance use treatment services funded by the Alabama Department of Mental Health. We are paid for these services and also for transportation. We understand substance use treatment services will not fall under the RCOs this year, but what will happen to the nonmedical transportation services we are providing to our patients. Will those services we paid for by the RCOs or the state?** A51. Non-emergency transportation services provided for substance abuse patients will continue to be funded fee-for-service under the current system.
6/6/16	**Q52. Will all, or a selected portion, of DME HCPC codes be included within the scope of an RCO contractor?** A52. Any currently covered DME services will be covered by the RCOs. For specific codes that the RCO may additionally choose to cover, please contact the RCOs that you may contract with.
6/6/16	**Q53. As I understand, pharmacy will be carved out of the RCOs and handled centrally by Medicaid. However, medicines administered in a medical office, or even a pharmacy, may be handled as a Medical Benefit by the RCOs with regulation and oversight by Medicaid that will set minimum standards?** A53. Physician administered drugs will be included as a covered service by the RCOs.

Benefits/Covered Services	
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6/6/16	**Q54. Once RCO's are established and services are being provided, what will be, if any, the relationship of mental health providers to the RCO's. Will all new Medicaid patients receive services only through an RCO or will the standard model of "fee for service" and primary care referrals still apply. Psychologists and supervised providers like an LPC are not included as core providers so it is unclear to me how a Medicaid patient will get assigned to a mental health provider.** A54. Although mental health providers can still be paid FFS by Medicaid for eligibility groups that are not included in the RCO program, please note that the vast majority of Medicaid clients will be IN the RCO program. Medicaid patients will be given a choice of certified, contracted RCOs in the region where they live. Medicaid patients are not "assigned" to mental health providers today. In the future, each RCO may utilize different referral processes.
6/6/16	**Q55. I am in the process of getting our applications together for the RCO's. Can you tell me if there is going to be an allowance for coverage in contiguous states; if patients are out of town in Mississippi, Georgia, Florida or Tennessee visiting family? We will be enrolling in the DME benefit to provide diabetic supplies.** A55. Please contact the RCOs you are contracting with. Medical care and services provided outside the State of Alabama for enrollees are covered services if and only if such services are rendered in-state and when medically necessary. Out-of-state providers must follow the enrollment procedures for the Agency. Providers bordering Alabama, within thirty miles of the Alabama state line, may be included within the RCO's network. All other out-of-state providers should be enrolled only for the treatment of emergent care or for services not otherwise available in-state.
6/6/16	**Q56. How will skilled nursing home facilities be impacted by the RCO's?** A56. All skilled nursing home facilities are excluded from the RCOs. Nursing Homes will continue to bill fee for service to Medicaid as they do today.

Benefits/Covered Services	
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6/6/16	**Q57. Currently under the Maternity Care Program, physicians become certified to administer and bill for SBIRT. Is it AMA's expectation that under the RCO, the pre-screening and screening would be a function of the Maternal Health Care Coordinator or would this remain a function of the PMP, after which the Enrollee would be referred to the RCO's Behavioral Health Program, if indicated? Please clarify.** A57. The screening is not a function of the care coordinator. The screening can only be done by a health care professional who has successfully completed the online tutorial. The care coordinators can conduct the prescreening or the PMP can conduct the prescreening - that is a decision of the RCO. The prescreening must be done and how the RCO plans to do it should be incorporated into their Behavior Health Program.
6/6/16	**Q58. Do Dentist fall under the RCOs program?** A58. No, dental services are carved out of the RCO program, but the services of an oral surgeon are included.
6/6/16	**Q59. Will ambulance services be covered under RCO's?** A59. Yes, ambulance services will be covered.
6/6/16	**Q60. Currently for some testing such as Cystic Fibrosis (CF), testing has to be run through the state lab. While a reimbursement amount does exist on the fee schedule, LabCorp traditionally would not be doing the testing and if so, do not see reimbursement for such. Under this new model, do you know if there will still exist a state lab and for testing such as CF would it still have to be treated the same way or will that be an RCO decision in how handled and reimbursed?** A60. The State Lab will still provide this testing and their services are carved out of the RCO. The RCO will not need to cover this testing.
6/6/16	**Q61. We are a Long Term Care closed door pharmacy. Do we need to contract/participate in the RCO? I see where LTC recipients and dual eligible recipients are not included. We service a few mental health/group home facilities.** A61. Pharmacy is carved out although if you are a DME provider you will need to contract with the RCOs that your recipients, if applicable, would be assigned to. It appears from your description that your clients will not participate in the RCO program.

Benefits/Covered Services	
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6/7/16	**Q62. Please provide clarification on pre-transplant services and any limits on transportation.** A62. Pre-transplant services, with the exception of transportation, are not covered by the RCOs.
9/12/16	**Q63. I work for an intensive residential treatment facility for 12-18 year olds. Almost all or our residents receiving mental/behavioral health services are foster children. Also, they are placed with us from 6 to 9 months. Will our site be required to participate under the RCO? We also work with DYS youth.** A63. No, you will not be required to participate under the RCO program.
10/18/16	**Q64. Are speech therapy services able to be provided in an outpatient hospital setting? There are no codes for ST services on the outpatient hospital fee schedule.** A64. Please review details in Chapter 19 of the provider manual. ST services are able to be provided to EPSDT and QMB only recipients in an OP hospital setting.
10/18/16	**Q65. I work for an intensive residential treatment facility for 12-18 year olds. Almost all or our residents receiving mental/behavioral health services are foster children. Also, they are placed with us from 6 to 9 months. Will our site be required to participate under the RCO?** A65. No, you will not be required to participate under the RCO program.
10/18/16	**Q66. We work with DYS youth. Will our site be required to participate under the RCO?** A66. No, you will not be required to participate under the RCO program.
10/18/16	**Q67. Is it allowable for children referred through EPSDT to visit a free standing PT provider?** A67. Yes, that is correct.

Payments, Reimbursements, Rate Development, and Capitation	
Date Added/ Revised	**Questions and Answers**
7/24/14	**Q68. Has the Alabama Medicaid Agency given additional thought to providing wrap-around payments to specialty providers such as Children's Hospital?** A68. This is still under evaluation.
7/24/14	**Q69. How will Medicaid administer the withhold?** A69. This is still under active consideration.
7/24/14	**Q70. Can the RCO withhold quality money from the Medicaid fee schedule rates for fee-for-service providers?** A70. Quality money cannot be withheld unless the provider is in agreement.
10/07/14	**Q71. Does the capitated rate include transportation costs?** A71. While nonemergency transportation costs are not currently included in the capitated rate for the RCO program AMA does intend to add in next iteration. Ambulance transportation costs are currently included in the capitated rate.
10/7/14	**Q72. Will AMA provide trend data on savings and capitation rates beyond year one?** A72. Trend data beyond year 1 is available in the 1115 Waiver document on the website. As was mentioned during the meeting held on July 22, 2014, the figures shared by Optumas are in extremely draft form. The goal is to hold actuarial workgroup meetings with the RCOs to discuss the rate setting process. These meetings, however, would not occur until actual rates are being determined. Therefore, rather than provide draft assumptions that will almost surely change, we feel that it would be best to hold off on getting into the detailed assumptions until the rate setting process begins.
10/7/14	**Q73. Will AMA consider reducing the quality withhold to 1-2.5%? Or make it a take-back penalty instead of a withhold?** A73. All financial related items are still under consideration. More details will be forthcoming in the financial solvency rules and the RCO contract.
3/26/15	**Q74. We are a pediatric provider in Region D. There are two RCOs that have applied for certification in Region D. One has also applied for Health Home Certification and the other has opted not to apply for Health Home Certification. How will this impact provider reimbursement for patients assigned to the RCO that is not a certified Health Home?** A74. Some of the probationary RCOs have qualified to provide Health Home services starting 4/1/15. All RCOs that go on to full certification are required to be qualified and provide Health Home services by 10/1/16 even if they have not qualified thus far.

Payments, Reimbursements, Rate Development, and Capitation	
Date Added/ Revised	**Questions and Answers**
3/26/15	**Q75. I have a couple questions for you regarding the RCOs. We do medical billing for several Alabama practices and have been submitting letters of intent to the RCOs. We have two practices that only accept Medicaid as a secondary insurance so they think they don't have to fill out these RCO LOIs. Our understanding was that patients who had Medicare as primary would have their secondary Medicaid claims handled as they have been in the past and not through the RCOs. What they are asking us is they do not sign a LOI and then later a contract with a RCO, will they still be able to submit Medicaid claims in 2016?** A75. Medicare beneficiaries will not be enrolled in RCOs. Providers will be able to submit fee-for-service claims directly to Medicaid for these individuals. An LOI is not required if the provider only accepts Medicaid as a secondary insurance to Medicare. Providers who did not sign an LOI initially could later decide to contract with one or more RCOs to provide services for Medicaid clients who are not also covered by Medicare.
3/26/14	**Q76. Does the capitated rate include transportation costs?** A76. Yes.
3/26/15	**Q77. Will the RHCs receive payments from RCOs or directly from Medicaid and whether these will be regular payments as before or quarterly settlements?** A77. More information will be forthcoming with the release of the finalized RCO Contracts. However, The Regional Care Organizations must negotiate and pay FQHCs and RHCs at rates no less than what it pays to other Providers who provide comparable services in its Provider Network. The agency will provide a wraparound payment if there is any difference between the rate paid by the RCO and the PPS rate.
3/26/15	**Q78. Do the RHCs have the option NOT to contract with Medicaid and if they do so then how will they get paid?** A78. Rural Health Clinics (RHCs) will not be required to contract with a Regional Care Organization. However, it will be necessary for RHCs to contract with one or more RCOs in order to be reimbursed for services provided to RCO-eligible patients. In this case, the RCO must negotiate and pay RHCs at rates no less than what the RCO pays to other Participating Providers who provide comparable services in the RCO's Provider Network. The Agency will provide a wrap-around payment if there is any difference between the rate paid by the RCO and the PPS rate. Also, Regional Care Organizations will be required to contain an adequate number of providers, as determined by the Agency.

Payments, Reimbursements, Rate Development, and Capitation	
Date Added/ Revised	**Questions and Answers**
4/15/15	**Q79. It is our understanding the rates will be developed using statewide data and then adjusted based on regional adjustment factors.** **1. Would the AMA consider making the statewide data available for the June 2015 and January 2016 rate meetings to allow the RCOs to validate the statewide assumptions used in the rate development along with the calculated regional factors?** **2. Alternatively, would the AMA provide regional summaries that can be used to validate the data used to create the regional factors?** A79. Only data for each RCOs regional will be distributed. Sharing State-wide data would be a conflict of interest with other RCOs and would cause concerns with regard to HIPPA violations. AMA will consider providing summary level information at the regional level. There remain concerns with regards to conflict of interest with other RCOs.
4/15/15	**Q80. Currently, the rates are developed at the "super cohort" level. Can the AMA comment on the rate cells that will ultimately be used in the program?** A80. Draft analyses includes approximately 20 individual rate cells that roll up into the 6 cohorts presented. The more detailed list of rate cells include splitting cohorts by age and gender as well as splitting the delivery kick payment into 'normal' and 'high risk' rate cells.
4/15/15	**Q81. At what point does the AMA anticipate releasing rates for these rate cells?** A81. Rates will be developed between January 2016 and June 2016. This will be an open process with significant communication between the State and the RCOs. The goal is to have rates for FY17 determined in June 2016.
4/15/15	**Q82. How do the RCO savings assumptions take into account the existing Health Home programs?** A82. Rate development will incorporate assumptions for Statewide Health Home expansion in FY16. From there, managed care savings begin in FY17 and take into account savings already achieved and accounted for within the Health Home program.
4/15/15	**Q83. Will the AMA account for the fact that certain regions have had these health homes in place longer than other regions and will therefore see a more limited managed care impact?** A83. For the current estimates, rates are built at a statewide level, it is assumed that a full year of the Statewide Health Home program will put all regions on a similar starting point in terms of Health Home management. Rates are then regionally adjusted to determine region specific rates. For actual rate setting, we will consider applying regional factors prior to RCO savings assumptions in order to have the ability to vary savings by region to the extent that it is deemed appropriate.

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Date Added/ Revised	**Questions and Answers**
4/15/15	**Q84. Can the AMA provide additional information related to the Access Payments to hospitals included in the current rate development? Specifically, how are these calculated and what services are they intended to cover?** A84. A summary for the methodology used to allocate the Access Payments will be provided. Dollar amounts for the Access Payments can be seen within the summary buildup labeled AL DRAFT Year 1 RCO Expenditure Buildup Detail'. These dollars are added to hospital service costs.
4/15/15	**Q85. Can the AMA provide additional guidance on how rates will be chosen within the actuarial rate ranges set by Optumas?** A85. Optumas will develop an actuarially sound rate range. The State will have the ability to choose a payment rate within that range.
4/15/15	**Q86. How will the AMA and Optumas derive an actuarially sound kick payment for OB services, especially since the current Best Start Programs that pay the delivery charges do not submit claims to the Agency?** A86. The maternity kick payment will be established utilizing a combination of FFS data, encounter data (MCP District's to report encounters back to Jan 1, 2014), and MCP District Financials. Rates have been set in an actuarially sound manner for the State for the last few years and this will continue into the RCO capitation.
4/15/15	**Q87. What about the costs for medically necessary non-OB services that are authorized?** A87. To the extent that these costs exist within the historical data, they will be included within the kick payment.
4/15/15	**Q88. Does the AMA anticipate using a risk adjustment process to account for selection among RCOs in each region? If so, which risk adjuster will be used?** **Will the process be prospective or concurrent?** **We would recommend a concurrent process as the program is implemented, transitioning to prospective after sufficient experience is collected.** **Will national risk weights be used or will Alabama-specific weights be calculated?** A88. Yes, a risk adjustment process is anticipated for selection among RCOs in each region. The tool and methodology is currently in the process of being determined. We will share the details when they are decided upon.

Payments, Reimbursements, Rate Development, and Capitation	
Date Added/ Revised	**Questions and Answers**
4/15/15	**Q89. What will be included in the kick payment?** A89. The services included within the kick payment is a State policy decision that is still being determined.
4/15/15	**Q90. What will be the timing/payment schedule for risk adjusted rates?** A90. A risk adjustment process is anticipated for selection among RCOs in each region. The tool and methodology is currently in the process of being determined. We will share the details when they are decided upon.
4/15/15	**Q91. How will the AMA account for individuals in the risk adjustment process that opt out of managed care?** A91. An individual who opts out of managed care would not be included within the analyses. Until that individual opts out, they would be included.
4/15/15	**Q92. If certain RCOs choose not to participate in the PCNA program, then the need for risk adjustment becomes very important since by default the chronic and more costly patients will be aligned with the Health Home participating RCOs. How does the AMA and Optumas plan to account for this selection bias?** A92. A risk adjustment process is anticipated for selection among RCOs in each region. The tool and methodology is currently in the process of being determined. We will share the details when they are decided upon. Although the exact methodology is not yet determined, the purpose for risk adjustment will be to account for the bias discussed within this question.
4/15/15	**Q93. It is our understanding Alabama Medicaid currently has certain benefit limits in place. If an RCO decides to lift this limit for its beneficiaries due to managed care initiatives (i.e., PCP visit limits to encourage continuation of care and ER Avoidance).** **How will the excess visits be handled?** **Specifically, will they factor into the risk score calculation and will these encounters claims be included in future rate setting?** A93. If an RCO decides to lift certain benefit limits, those excess benefits will be carved out from future rate setting development when encounter data is used. The risk score calculation methodology is still being determined.
4/15/15	**Q94. Similarly, will the state consider claims paid by RCOs that are typically considered non-state plan services? Some of these services will be provided as cost- effective alternatives to state plan services in order to reduce the overall costs and better manage the care for members.** A94. All non-state plan services will be excluded from future rate setting development when encounter data is used, consistent with requirements in the CMS Checklist

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Date Added/ Revised	**Questions and Answers**
4/15/15	**Q95. How will the PCNA and Best Start case management fees be incorporated in the capitation rates and at what levels?** A95. These fees will are to be included within the non-medical loading component of the capitation rate. This component will be developed using similar levels seen within other State managed care programs.
4/15/15	**Q96. We are concerned about the application of the 5% withhold on the cash flow for RCOs. We think that the 5% is very high given that there are other fees being levied, such as stop loss funding.** **Would AMA consider applying the withhold to the medical portion of the rates only? Therefore, any case management fees, administrative fees, profit, hospital funding, etc. would be exempt from a withhold.** A96. This is a State Policy decision and will be considered.
4/15/15	**Q97. Is the AMA still planning on stop loss purchasing at the state level, or will the RCOs be allowed to purchase their own stop loss?** A97. Stop loss purchasing will be at the State level. To the extent that RCOs would like to purchase additional stop loss insurance over and above what is required within the Agency's program that is permitted, as long as there is no overlap in coverage with the Agency's program.
4/15/15	**Q98. When developing the administrative build up, will the AMA consider the reality that the basic administrative expenses are often the same for low pmpm rate cell as they are for a higher PMPM rate cell?** **Therefore, would the agency and Optumas consider a weighted methodology in an effort to represent the differences? In other words, a straight percent of premium administrative load does not reflect the true cost picture in all cases.** A98. The State and Optumas will recognize the fact that there are both "fixed" and "variable" pieces of the administrative component of the non-medical load. We will ensure that the resulting percentage of premium administrative load translates to a PMPM that is deemed reasonable. This is intended. The delivery cohort represents a count of deliveries. The goal of the total blended PMPM is to capture the Per Member Per Month expenditure for the program which includes the total dollars (including delivery dollars) divided by the total member months.

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Date Added/ Revised	**Questions and Answers**
4/15/15	**Q99. VIVA Health's actuaries have reviewed both the July 2014 and January 2015 white papers and related exhibits provided by Alabama Medicaid. Together with our actuaries, we have compiled the following questions for Optumas and the Alabama Medicaid Agency.** **Understanding the payment rates are not set in total, but by rating cohort, the member month totals do not include the "Delivery" cohort, but the weighted totals do account for them. We would like to confirm that this is intended.** A99. This is intended. The delivery cohort represents a count of deliveries. The goal of the total blended PMPM is to capture the Per Member Per Month expenditure for the program which includes the total dollars (including delivery dollars) divided by the total member months.
4/15/15	**Q100. The weights used to calculate the total "blended base PMPM" do not produce the total blended rate on the exhibit? The total blended base pmpm is actually calculated as the weighted average of the aid category pmpms, weighted by the FY13 member months. This is causing the blending weights to be 13%/87% since there is no blending of the member months from each FY.** A100. The 25%/75% blend is done at the detailed rate cell level. Rate cell mix among rolled up more high level cohorts (and program total) changes between FY12 and FY13. This changes the implied blend percentages on a rolled up basis. The total PMPM is there for an estimated overall program PMPM. Capitation payments will be paid at a rate cell level so that the RCOs are not at risk for membership mix among cells.
4/15/15	**Q101. Significant shifts in payments rates occurred in part due to the regional factor changes.** **What is causing the regional rating factor to decrease so drastically for Region B?** **Other regions saw changes that were minor in comparison. What are the causes of the shifts within the regions?** A101. Regional factors shifted when utilizing the most up to date data available (FY13). Additionally, Optumas and the State worked to improve the allocation of the Access Payments which did impact the spread of those dollars among regions. As we continue into actual rate development, these factors will again be revisited.

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Date Added/ Revised	**Questions and Answers**
4/15/15	**Q102. What caused the substantial increase in projected membership from July 2014 to January 2015? Region B and Region D saw membership increases of 16% and 12% respectively, both driven by increases to the MLIF and SOBRA Child cohorts. Prior to the July 2014 white paper, the regions' membership reported by Alabama Medicaid was similar to the membership reported in January 2015.** A102. Additional data was available to revisit the membership projections. Medicaid membership through the end of CY14 has increased more than previously anticipated. As a result, projections into the first year of capitation have increased. Additionally, July 2014 estimates assumed a start date of FY16 for capitation. The current anticipated start data for capitation is now FY17. This added an extra year of growth projection to the membership estimates.
4/15/15	**Q103. We would like clarification on what is in the access payments as well as how they are allocated across rating cohort.** A103. A summary for the methodology used to allocate the Access Payments will be provided. Dollar amounts for the Access Payments can be seen within the summary buildup labeled 'AL DRAFT Year 1 RCO Expenditure Buildup Detail'. These dollars are added to hospital service costs.
4/15/15	**Q104. Please provide additional detail about the development of the "Program Change Impact"? In the July white paper this was included but we don't see an updated version. In addition, the program change information we do have so far does not include how some of the adjustments were determined. We need this information to understand the rate development.** A104. The majority of the program change impacts are adjustments that account for increases within the Medicaid Fee Schedule. The data was re-priced to the most up to date known fee amount or the anticipated fee amount for the FY17 capitation time period.

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Date Added/ Revised	**Questions and Answers**
4/15/15	**Q105. Please provide additional detail about the development of trends used to project the blended base pmpm.** **Will these amounts change in each iteration received from the state?** **If experiences was used to derive the amounts, what additional considerations are being made for the trends in the projection period?** A105. Trends are developed by analyzing year over year as well as rolling average trends on a normalized basis – accounting for programmatic changes and rate cell mix. These amounts will be revisited for the actual rate development process where the most recent available data will be taken into account. In addition to Alabama historical data, considerations will be given to other State's (specifically those moving to or in a managed environment), as well as public sources of information.
4/15/15	**Q106. Please describe the methodology used to set the weights for blending the two fiscal year's adjusted PMPM.** A106. Generally, we like to give more credibility to the most recent available complete data. For this reason, the FY13 time period was given more weight than the FY12 time period. 75% was chosen as the weight for FY13 since the more recent data should more appropriately capture the risk of the population.

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Date Added/ Revised	**Questions and Answers**
4/15/15	**Q107. What assumptions were made in developing the RCO savings? What was the basis used to determine what the 1st year savings would be?** **Why was there a shift from the prior report? The report seems to imply that these levels were possibly backed into based on the capitation level. Is this the case?** A107. The RCO savings assumptions were not backed into based on the capitation level. Similar savings assumptions were used for the two reports. The differences are driven by the additional year of data containing a different mix across service categories and rate cells, which are the basis in which the savings are developed. High level bullets behind RCO saving assumptions: • Current system utilization driven. RCO management will incent appropriate utilization in the appropriate setting. • Current system unmanaged and reimbursed Fee-for-Service (FFS). Through the 1115 waiver, the system will move to a managed environment with at risk capitation where RCOs will have incentive to be efficient. • Many probationary RCOs are partnered with Managed Care Organizations (MCOs) who have significant experience that can be leveraged to achieve savings. • AL hospital admissions per thousand are 17% - 23% higher than the US average showing there is room for significant improvement. Savings assumed would result in Alabama remaining above the national average. • AL emergency room visits per thousand are 15% - 17% higher than the US average showing there is room for significant improvement. Savings assumed would result in Alabama remaining above the national average. • AL inpatient days per thousand are 13% - 14% higher than the US average showing there is room for significant improvement. Savings assumed would result in Alabama remaining above the national average. • Savings assumptions not only based on AL data but also experienced seen achieved in other States moving from FFS to managed environments. • As an example, one State that recently went through the waiver process moving to a full MCO environment has shown 4.0% - 6.0% program savings per year over the first two years. Note these savings reflect the total savings after accounting for all components of the process (variations in trend, MCO savings, and administrative payments). A full MCO environment is assumed to be able to achieve more savings than the RCO model. Additionally, this State moved to full MCO capitation, however, already had management for half of the population and one third of the dollars in place before the waive.

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Date Added/ Revised	**Questions and Answers**
4/15/15	**Q108. Dr. Williamson has indicated that Alabama Medicaid has the lowest per member per month cost of any Medicaid program in the country. He said our problem is not utilization but rather the number of eligible Medicaid recipients. Given that, how is the RCO savings percentage (which substantially decreases the rates) justified?** A108. It is difficult to compare PMPM expenditures across State's. Each state has a very different mix of membership. Alabama, for example, is much more heavily weighted towards children (who tend to be less costly) within its program than other States. Please reference the above response for RCO savings justifications.
4/15/15	**Q109. What would the rates look like in the absence of the 1115 waiver and the need to have the RCOs offset the federal funding provided to the state through the waiver?** A109. In the absence of the waiver, RCO rate development would remain unchanged. The actuarially sound rate ranges are set independent of any type of waiver utilized by the State. The roadblock would be that the new federal funding received through the waiver would no longer be available which would significantly impact the ability for the State to transform the Medicaid program.
4/15/15	**Q110. The Medicaid actuaries have set managed care savings at 6.3%, which we understand includes the program change of expanding the Health Homes throughout the state. We also understand that Medicaid will use FY15 data in the final premium projection. That FY15 data will include experience under the expansion of the health homes. Will the 6.3% assumption drop correspondingly to account for savings already achieved through the health home expansion reflected in the FY2015 data?** A110. The FY15 data will be reviewed to see the impacts of the Health Homes on the emerging experience. To the extent that the Health Homes have shown improvements, RCO savings in year one of capitation will take that into consideration. Additionally, assumptions for the impacts of the Health Homes continuing through FY16 will exist as a part of the rate build.
4/15/15	**Q111. We would like additional detail regarding all items that comprise the non-medical load. More specifically, can you describe all items that make up the administrative portion of the non-medical load?** A111. The administrative portion of the non-medical load is included to cover things like management expenses/fees, compensation, interest expense, occupancy, depreciation and amortization, marketing costs, affiliate admin services, along with any other non-medical expenses the RCO incurs.

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Date Added/ Revised	**Questions and Answers**
4/15/15	**Q112. Please describe the methodology used to develop the regional factors.** A112. Historical PMPMs are compared across regions to develop the regional factors. PMPM expenditures are adjusted for programmatic changes and normalized for rate cell mix among each rolled up cohort. The resulting factors are then applied to the statewide rate build on a budget neutral basis to create estimates for each of the five regions.
4/15/15	**Q113. Our understanding is Medicaid currently pays for non-emergency transportation mostly through member reimbursement and this may include receipts for cab rides, bus fares, etc.** **Are these costs included in the base year data used to develop the premium rates?** **Do the rates anticipate a different model of paying for these costs, such as an RCO contracting with a transportation vendor, which would be more efficient but likely to increase utilization?** A113. These costs are included within the base data and are included within the rates. No adjustment is explicitly made for moving to a transportation vendor.
4/15/15	**Q114. Were administrative cost loads adjusted for the increased reporting requirements relative to the 42 RCO quality metrics?** A114. No. The 42 RCO quality metrics are expected to be achieved within the non-medical loading provided which is in line with what is seen in other States. Additional funds outside of the capitation payments may be made available and linked to these metrics. The State is still in the process of determining this policy decision.
4/15/15	**Q115. Please provide administrative cost loads by aid category specific to each region.** A115. Non-Medical Loading = Admin + Profit/Risk/Contingencies ABD: 6.5% SOBRA Child: 8.5% Delivery: 8.5% MLIF: 8.5% BCCTP: 6.5% Transitional: 8.5%
4/15/15	**Q116. Does the rate development include adjustments related to any additional services the RCO will be required to cover that were not required to be covered in the experience periods?** A116. No.

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Date Added/ Revised	**Questions and Answers**
4/15/15	**Q117. Is it Medicaid's intent that the access payments will continue to be paid by the RCOs?** A117. This is a reimbursement decision between the RCOs and the providers. The capitation payment will aim to cover the costs of services inclusive of the access payments. It will be up to the RCOs to determine contracting with their providers.
4/15/15	**Q118. When will the RCOs get the additional data, such as the access payments and administrative costs that Optumas used when developing the rates for the July 2014 and January 2015 draft rates?** A118. Most current access payment methodology will be provided. Additionally, more details behind the administrative components is given above. Levels of access payments will continue to change as different years of experience become available for actual rate setting. Additionally, the administrative component will continue to be reviewed to ensure the appropriate levels are included within the capitation rates.
4/15/15	**Q119. When will actuary-to-actuary discussions begin?** A119. The State has provided multiple meetings to discuss the progress of the RCO expenditure estimates. These are scheduled to continue periodically throughout CY15. Beginning in January 2016, FY17 rate development will begin and regular meetings will be scheduled to discuss the progress of rate development.
4/15/15	**Q120. Have subrogation, fraud waste and abuse and coordination of benefit recoveries been added back to the claims experience since the contract as currently written seem to disallow the RCOs from retaining these dollars?** A120. No, none of these have been added back into claims experience. To the extent that the historical data includes fraud waste and abuse, we have not removed that from the base.
4/15/15	**Q121. Has the money paid to the PMP and the health home been added to the RCO payment since the RCO will assume the PMP payment and health home responsibilities?** A121. Yes, these payments are meant to be accounted for within the administrative component of non-medical loading.
4/15/15	**Q122. Is the RCO's payment to non-participating providers limited to the amount Medicaid would pay? If not, the RCO will have to pay billed charges and that needs to be factored into the rates. (For example, emergency hospitalization outside the state can be extremely expensive).** A122. Services rendered to RCO members outside the state will be included within the base data and therefore will be included in the prospective capitation payments.

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Date Added/ Revised	**Questions and Answers**
12/02/15	**Q123. Where can I locate RCO regulation on provider reimbursement for non-par providers?** A123. There is no administrative rule that specifically addresses non-participating provider reimbursement; however, there is a rule regarding minimum FFS rates, see Rule No. 560-X-62-.10 Minimum Fee-For-Service Reimbursement Rates (http://medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3.5_Rules.aspx).
12/02/15	**Q124. Will reimbursement rates to individual providers be affected by the provider's core measures such as immunization rates, ER utilization, etc.?** A124. The RCOs will determine reimbursement incentives to providers. The RCO must contract with any willing hospital, doctor or other provider to provide services in the Region if the provider is willing to accept the payments and terms offered to comparable providers.
12/03/15	**Q125. The letters of intent say that RCOs must pay providers at the "prevailing" Medicaid rates. Define "prevailing".** A125. The minimum Fee-for-Service reimbursement rates that an RCO shall pay providers for applicable Medicaid services provided to a patient shall be the prevailing Medicaid Fee-for-Service payment schedule, unless otherwise jointly agreed to by a provider and an RCO through a provider contract or mandated by Federal law.
12/03/15	**Q126. How will reimbursement work for patients we see who are assigned to other RCOs?** A126. As long as the provider is contracted with the RCO, he or she can see patients that are not on the panel. If the patient is not eligible, the patient can see any provider for fee-for-service. If the patient is not assigned to a PMP but assigned to an RCO, the payment will come from the RCO – not the Medicaid Agency. If the provider is not contracted with the RCO and if the RCO network is unable to provide necessary services covered within the RCO program, the RCO will coordinate with the non-participating provider for payment. The cost to the patient will not be greater than if the services were furnished in network.
12/03/15	**Q127. Will CRNP reimbursement be the same for all provider types?** A127. Medicaid's Administrative Code, Rule No. 560-X-62-.10 addresses provider payment which states that providers will be paid the "prevailing rate" which will not be less that Medicaid's current minimum fee-for-service or the rate jointly agreed to by the provider and the RCO. Rule can be found at the following URL: http://wwwW.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.4_Procurement.aspx
12/03/15	**Q128. If I have a clinic in two different regions, A and B, and some patients in region A travel to the clinic in region B, how will we be paid?** A128. Payment is tied to the patient's RCO. If the same provider sees patients at both locations and is contracted with the patient's RCO, payment will not be impacted.

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Date Added/ Revised	**Questions and Answers**
4/15/15	**Q129. Is the RCO's payment to non-participating providers limited to the amount Medicaid would pay? If not, the RCO will have to pay billed charges and that needs to be factored into the rates. (For example, emergency hospitalization outside the state can be extremely expensive).** A129. Services rendered to RCO members outside the state will be included within the base data and therefore will be included in the prospective capitation payments.
2/15/16	**Q130. Can the Agency please tell us how they pay for DME claims that must be manually priced? The provider manual does not provide this information. For example is it xx% of invoice or some other methodology?** A130. For wheelchairs for kids it is MSRP – 15% for power-related & MSRP – 20% for non-power related; E1399 is invoice + 20%. The specialty trach supply is invoice +20%. ACDs are paid at cost (invoice only). Procedure code K0108 (miscellaneous code for wheelchair component) is also MSRP -20%
2/15/16	**Q131. Is Occupational Therapy covered for acute conditions in a hospital outpatient setting for non-EPSDT recipients? Reference Chapter 37** **37 Therapy (Occupational, Physical, and Speech)** **This chapter regarding therapy services is specifically designed for therapy providers who meet either of the following criteria:** **• Provider receives a referral as a result of an EPSDT screening exam and possesses a Patient 1st/EPSDT Referral form (Form 362) as a result of an abnormality discovered during the EPSDT exam** **• Provider treats QMB recipients** **Physical therapy is also covered for acute conditions in a hospital outpatient setting for non-EPSDT recipients. For more information regarding this, refer to Chapter 19, Hospital.** **The policy provisions for EPSDT referred therapy providers can be found in the Alabama Medicaid Agency Administrative Code, Chapter 11.** A131. Yes, Occupational Therapy for non-EPSDT recipients is covered for acute conditions in a hospital outpatient setting.

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2/15/16	**Q132. Does the kick payment ONLY apply for Pregnant Women category? Is there a monthly capitation and/or a kick payment for a women who is already on Medicaid prior to becoming pregnant?** A132. No. Every delivery, regardless of edibility category, receives a kick payment. A monthly capitation for women already on Medicaid prior to becoming pregnant will be paid in addition to the kick payment. Please see Section 18.2.7 of the Alabama Regional Care Organization Draft Contract Version 3 October 23, 2015.
2/15/16	**Q133. We cannot identify any site of service differential - does this exist for Alabama Medicaid fee schedules? If so, can they provide us additional information?** A133. Under the physician fee schedules, some claims (E&M) are paid at a higher rate for Urban/Rural and for teaching hospitals, otherwise there are no site differentials for physician reimbursement.
2/15/16	**Q134. We cannot identify any adult vs. peds fee differentials – does this concept exist for Alabama Medicaid fee schedules? If so, how does it work and can they provide us with additional information?** A134. Under the physician fee schedules, adults vs peds. differentials do not apply.
2/15/16	**Q135. Does the AMA intend to modify the copay policy to reflect the Affordable Care Act $0 copay requirements for preventive and wellness visits? If so, will those copays be added to the data for rate setting purposes?** A135. The current copay rules are provided in the below link. Currently, the agency does not anticipate changing the rules from those published, but if, and when, the agency updates the copay rules, they will be published to this location: http://www.medicaid.alabama.gov/documents/4.0_Programs/4.2_Covered_Services/4.2_Covered_Services_Summary_6-13.pdf
2/15/16	**Q136. Will the AMA allow the RCOs to collect ER copays on children less than 19 years?** A136. No.
2/15/16	**Q137. Is a monthly capitation payment received in an Enrollee is in the "Delivery" aid category? Does a pregnant member have to be in a specific aid category for the kick payment to be received?** A137. Any pregnant member eligible for the RCOs receives the kick payment once Medicaid receives the claim for the delivery, regardless of aid category. Other than SOBRA Maternity members, a monthly capitation payment for the given members rate cell is received in addition to the kick payment.

Payments, Reimbursements, Rate Development, and Capitation	
Date Added/ Revised	**Questions and Answers**
2/15/16	**Q138. How will an RCO identify how providers are paid - rural vs urban fee schedule?** A138. RCO can identify the provider as rural using the provider's county. AMA will release the rural counties shortly.
2/15/16	**Q139. Is there a separate urban and rural rate for the teaching physicians?** A139. No. There is a rate for rural and teaching, but there is no rural teaching rate.
4/15/16	**Q140. Will we continue to bill hospital inpatient and outpatient services to Alabama Medicaid or will we be billing claims to the RCO?** A140. If the recipient is a member of an RCO, claims should be billed to their respective RCO. If the recipient is not a member of an RCO, claims should still be billed to Medicaid. RCO membership can be determined when verifying eligibility.
6/6/16	**Q141. Are psychiatric services received during an admission to an acute care inpatient hospital subject to the $50 per admission copay? (ages 21-64)** A141. Yes, these services are subject to the $50 copay. Please refer to Chapter 19 of the Provider Manual for any exceptions.
6/6/16	**Q142. Will we continue to bill hospital inpatient and outpatient services to Alabama Medicaid or will we be billing claims to the RCO?** A142. If the recipient is a member of an RCO, claims should be billed to their respective RCO. If the recipient is not a member of an RCO, claims should still be billed to Medicaid. RCO membership can be determined when verifying eligibility.
6/6/16	**Q143. How are copays applied to DME claims? Does each item have a copay or does the copay roll-up to the whole allowed amount per claim?** A143. Each DME item has a copay. Please refer to Chapter 14 of the Provider Manual for the list of DME items and their respective copay amounts.
6/6/16	**Q144. Will the maternity kick payment be made separately from the monthly capitation payment? What file format will be used?** A144. The kick payment will be included in the monthly capitation payment but separated out as a different line item. The MGD-01-00-M report separates the cap category. The file format 835 will be used.

Payments, Reimbursements, Rate Development, and Capitation	
Date Added/ Revised	**Questions and Answers**
6/6/16	**Q145. How will the RCOs be notified of fee schedule updates? Is there a regular schedule that you follow?** A145. Fee schedule updates are published on AMA's website, and the date is included of when the update occurred. The Agency is currently looking at the frequency of each schedule's updates and the processes around how those updates occur as well as which information is included. The Agency is looking to improving this process and will provide an update to all of the RCOs in a couple of weeks. The most recent DME fee schedule can be located on the Agency's website at the following link: http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx.
6/6/16	**Q146. Please provide the copay amount per admission for a free-standing psychiatric hospital for each age range? 0-17; 18-21 & 65+** A146. Copayment does not apply to free-standing psychiatric hospitals for populations under 21. For over 65, the copayment amount is $50 per admission. Please refer to the Provider Manual Chapter 104 for 65 and over for any exceptions.
6/6/16	**Q147. Will benefits still be checked via Medicaid's portal? If so, will the patient's benefits show which RCO he or she is enrolled with?** A147. Yes, the patient's eligibility file will continue to be checked through the Agency, and this file will show a patient's RCO membership.
6/6/16	**Q148. Please advise how allergy testing and injections are covered or allowed. Is there a copay applied for allergy testing and/or allergy injections?** A148. The recipient has the same copays as they do today for the doctor's visit only; they are not responsible for the testing and injections.
6/6/16	**Q149. Is there any value assigned to increased kick payment for non-pregnancy related mother issues?** A149. Yes, the kick payment is all-inclusive.
6/6/16	**Q150. Should DME's contract/enter into LOI's with RCO contractors for medical equipment and supplies? What if the DME provides services in the patient's home?** A150. To be eligible for payment for services to clients enrolled in RCOs, a contract with the recipient's RCO will be necessary.
6/6/16	**Q151. Will RCOs pay FQHCs the Medicaid Fee Schedule and then Medicaid will pay the wrap around paymen?/ If so, how will this impact the fee schedule?** A151. Yes. The fee schedule should not be impacted.

Payments, Reimbursements, Rate Development, and Capitation	
Date Added/ Revised	**Questions and Answers**
6/6/16	**Q152. I work for a DME company that services the entire state of Alabama, therefore meaning we will have to be in contract with each region. I have a couple of questions regarding how my job as a Medicaid biller will change when all of this goes into effect. First, will each region have a different mode of submission? For example, Region A may request that I fax my PA request, Region B may request that I mail it, and Region C may have a web portal I can use. Can/should I expect, due to being in contract with each, to have to learn several sets of rules for each different region? Secondly, will those rules for approval still be based on the requirements listed in the Alabama Medicaid manual, or will they depend on the region and the regulations that they create?** A152. Please contact the RCOs you are contracting with regarding billing and prior authorization policies. You might have several different methods of billing depending on the RCOS and their claims administrators. RCO prior authorization criteria cannot be more restrictive than existing Medicaid criteria unless approved by Medicaid.
6/6/16	**Q153. If a beneficiary assigned to an RCO receives non-emergency treatment covered by Medicaid from a physician practice that is not contracted with the RCO, is the RCO obligated to reimburse the physician practice for those services? If the RCO is not obligated to reimburse the physician practice, is the Alabama Medicaid Agency obligated to reimburse the practice?** A153. The RCO is not responsible for payment to non-par providers for non-emergency services. Additionally, Medicaid is not responsible for payment for non-emergency services received by an RCO beneficiary. Providers must verify eligibility prior to rendering services to recipients. If the recipient is assigned to an RCO that the provider is not contracted with, the provider should contact that RCO for guidance.
6/6/16	**Q154. Will Nurse Practitioner and Physician Assistant services provided through a walk-in clinic (also known as retail clinic, convenient care clinic, NOT an urgent care center) be covered under the RCOs?** A154. All providers of services through the RCO's must be enrolled with Medicaid. You will need to enroll with Medicaid before contracting with the RCOs.

Payments, Reimbursements, Rate Development, and Capitation	
Date Added/ Revised	**Questions and Answers**
8/8/16	**Q155. At the last rate setting meeting, the estimate for NET services was PMPM $2. Please provide details around benchmarking and services that Agency sees that would be included.** A155. We reviewed NET data from several different State Medicaid programs (including States in the Midwest, West, and Southeast) that we feel are similar in nature to Alabama. Services included nonemergency encounters/trips, nonemergency mileage, wheelchair van trips, ancillary transportation costs such as parking fees and tolls, mini-bus trips, and other transportation systems. RCOs are encouraged to use the amount loaded into the eventual capitation rates to develop an NET program specific to the Alabama Medicaid population needs that will help to improve the quality of care of the population.
8/8/16	**Q156. For the two different DME fee schedules (DME POP and DME EPSDT REFERRAL) if a code overlaps is it applicable to all ages, if a code is only on the EPSDT Referral and not on the DME POP does this mean the code is only applicable to those ages of EPSDT 0-20? Overlap refers to instances where codes are on both fee schedules (DME POP & DME EPSDT). When a code is only found on DME fee schedule or the other, does it only apply to that particular age group?** A156. The DME POP Fee schedule are the covered procedure codes for the entire Medicaid population, recipients age 0-999. The DME EPSDT Referral is covered procedure code for recipients age 0-20 and requires an EPSDT referral. If a procedure code is on both fee schedules, it is covered for adults and children.
8/8/16	**Q157. Do FQHC or RHC currently bill AMA at the individual provider level or at the facility/center level?** A157. Currently, FQHCs and RHCs bill at the individual provider level.
8/8/16	**Q158. Can you please tell us what impact the end of enhanced primary care payments ("the bump") effective August 1, 2016 will have on FQHCs and rural health centers? Will they have their payments reduced as well?** A158. FQHCs and RHCs do not receive the bump.
9/12/16	**Q159. Do FQHC or RHC currently bill AMA at the individual provider level or at the facility/center level?** A159. Currently, FQHCs and RHCs bill at the individual provider level.
10/18/16	**Q160. If a covered billing code for a physician requires a copay, would the copay apply if the services is eligible to be provided by telemedicine? Typically there is the assumption that it would be collected.** A160. General AL Medicaid rules apply to telemedicine services.

Payments, Reimbursements, Rate Development, and Capitation	
Date Added/ Revised	**Questions and Answers**
10/18/16	**Q161. Are the APR/DRGS tied to the 10/1 go-live date?** A161. The Medicaid Agency released a Provider Alert dated July 8, 2016 stating: Due to the postponement of the Regional Care Organizations and budget uncertainty, the October 1, 2016, implementation date for APR-DRG pricing for hospital inpatient stays will be delayed. The Medicaid Agency announced September 14, 2016 after the Alabama Legislature had concluded a special session during which additional funding was approved for Medicaid that the Agency requested CMS approval for a revised July 1, 2017 go-live date. APR-DRGs will be implemented concurrently with the RCO go-live as previously planned. The new go-live date is subject to CMS approval.
10/18/16	**Q162. Are Out-of-State Providers able to contract with RCOs?** A162. Section 9.8.1 in the RCO contract provides the following with respect to providers outside of 30 miles: All other out-of-State Providers should be enrolled only for the treatment of emergent care or for services not otherwise available in-State. The Contractor is not obligated to pay Out-of-State Providers any more than the amount that would have been paid if the service had been provided under the Medicaid Fee-For-Service Program. The Agency shall not be responsible for any amounts due or paid in excess of amounts that would have been paid under the Medicaid Fee-For-Service Program.
10/18/16	**Q163. Please provide clarification on the benefit for IV therapy and whether or not this would be considered a covered benefit through the RCO agreement. We have been contacted by several home IV therapy providers regarding contracting and when we looked these providers up in the Alabama Medicaid provider file, they are listed as "pharmacy" providers and not DME (which is where the infusion codes reside). We are clarifying that these provider types would be able to bill and be reimbursed for the S codes identified on the DME fee schedule (home infusion codes) and that we can identify these providers as a DME provider type (contract type) rather than pharmacy. In addition, please clarify if it is the expectation that the IV Therapy providers would have to split bill their services to the RCO and Medicaid in order to be reimbursed. For Example: Pharmacy to Medicaid, Home Health to Medicaid and the supplies to the RCO?** A163. If a pharmacy bills the IV drugs today to pharmacy (which is our understanding how most bill), the pharmacy would continue to bill the drugs through pharmacy in the RCO world, and these drugs would not be subject to the RCO oversight. However, the ancillary supplies (such as tubing, machines, needles, etc) are currently billed through DME, and this portion will be subject to RCO oversight, and these entities would need to enroll in their RCOs for this purpose. These pharmacies are currently (or should be) enrolled as both pharmacy and DME. Their DME NPI will be subject to the RCOs, the pharmacy NPI not.

Payments, Reimbursements, Rate Development, and Capitation	
Date Added/ Revised	**Questions and Answers**
10/18/16	**Q164. If not enrolled by the Oct. 1 deadline, will Medicaid stop paying us directly, or at all?** A164. The RCO will reimburse you for services based on their contract with you; Medicaid will not pay you directly unless the recipient is not eligible for the RCO program or the services rendered are not covered by the RCO. The Oct. 1 2016 deadline has been delayed. Pending CMS approval, the new go-live date will be July 1st, 2017.
	Q165. Does multiple surgery reductions apply to Ambulatory Surgery Centers (hospital/freestanding) since they are on a fee-for-service schedule? If so, is it the same as the physician process? A165. If more than one covered surgical procedure is furnished to a Medicaid recipient in a single operative session, Medicaid pays the lesser of either the submitted charges or the full amount for the procedure with the higher predetermined rate less the copay amount. Other covered surgical procedures furnished in the same session will be reimbursed at the lesser of the submitted charges or at 50 percent of the predetermined rate for each of the other procedures, whichever is lowest. Physicians Chapter 28, provider manual: When multiple or bilateral surgical procedures that add significant time or complexity are performed at the same operative session, Medicaid pays for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure. This also applies to laser surgical procedures. Additional payments will not be made for procedures considered to be mutually exclusive or incidental. Mutually Exclusive procedures are services that cannot reasonably be performed at the same anatomic site or same patient encounter. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g., excision of a previous scar or puncture of an ovarian cyst) are performed during the same operative session, Medicaid reimburses for the major procedure only. CPT defined Add-on codes are considered for coverage when billed with the appropriate primary procedure code. Add-on codes are not subject to rule of 50 percent reduction. Additional information:Please see Alert on attached link re to NCCI edit implementation that affects physicians/ASC and OP hospitals: http://medicaid.alabama.gov/news_detail.aspx?ID=4015 Please see the January 2010 PI article, page 4 on bilateral surgeries and reduction in payment. This affects ASC/OP Hosp and physician claims: http://medicaid.alabama.gov/documents/2.0_Newsroom/2.3_Publications/2.3.7_Provider_News/2.3.7_10_January.pdf

Payments, Reimbursements, Rate Development, and Capitation	
Date Added/ Revised	**Questions and Answers**
11/10/16	**Q166. Our understanding is that Inpatient Psychiatric Facilities will continue to be paid per diem. Can you confirm that is so and can you provide the rates so we can load them by facility.** A166. Inpatient Hospital Psychiatric schedules recently released by the Medicaid Agency (dated August 15, 2016) outline the payment methodology for various psychiatric facilities and scenarios. These are also available at http://medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3_Regional_Care_Organizations.aspx. Rates for facilities paid on a per diem basis change annually and will be released nearer to the July 1, 2017 go-live date.
11/10/16	**Q167. When is the switch from per diem reimbursement to APRDRG reimbursement for inpatients expected to occur?** A167. The Medicaid Agency released a Provider Alert dated July 8, 2016 stating: Due to the postponement of the Regional Care Organizations and budget uncertainty, the October 1, 2016, implementation date for APR-DRG pricing for hospital inpatient stays will be delayed. The Medicaid Agency announced September 14, 2016 after the Alabama Legislature had concluded a special session during which additional funding was approved for Medicaid that the Agency requested CMS approval for a revised July 1, 2017 go-live date. APR-DRGs will be implemented concurrently with the RCO go-live as previously planned. The new go-live date is subject to CMS approval.
11/10/16	**Q168. How can the Enrollee find out more about pharmacy and dental benefits since they are not a covered service with the RCO?** A168. The Enrollee can find out more about these benefits through the Alabama Medicaid website and their Enrollee handbook that they receive upon enrollment.

Network Adequacy	
Date Added/ Revised	**Questions and Answers**
4/03/15	**Q169. For the 0.2 per 1,000 requirement for core specialists is the membership based on the entire RCO membership in the region of e.g. 220,000 for region B, thus we need 44 of each core specialty in the entire region plus we must have a core specialist within a 50 mile radius of any 1 RCO member?** A169. Correct. Each probationary RCO must contract with the required number of providers for every 1,000 enrollees assigned to that particular RCO. The number of required core specialists will be based on the specialties identified in Section 9.5.1.2. which requires your organization to have 44 of each type of specialists within a 50-mile radius. The 50-mile requirements states that an enrollee must have access to a provider within 50 miles of their place of residence. The Agency will be evaluating this based on geodesic distance ("as the crow flies"), and not driving distance.
7/24/14	**Q170. Are there any measures in place by the Agency or CMS related to time to appointment and office wait times? How would this data be collected to validate/demonstrate compliance?** A170. Section 22-6-153(h)(2) specifically requires AMA to establish by rule the service delivery network requirements. Please see Rule 560-X-62-.12 Service Delivery Network Requirements for additional information. The State can ask to review the managed care organization's policy and procedure to govern compliance. The State can ask for copies of the organization's reports/phone surveys, etc. Other elements for review to see if there is reason to monitor more would come from member services call reports and complaints logs.
12/07/15	**Q171. For transplant centers, I believe this only exists at UAB in Alabama. How can we be adequate if the member lives in e.g. Scottsboro?** A171. Transplant services are covered outside of the RCO Program. With regard to facilities, the requirement applies to outpatient dialysis centers which are licensed in accordance with the State Board of Health, Alabama Department of Public Health Chapter 420-5-5 as "End Stage Renal Disease Treatment and Transplant Centers."

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
7/24/14	**Q172. Will healthcare providers be automatically enrolled in an RCO or will they have a choice to not participate and continue to provide services under FFS?** A172. Healthcare providers will not be automatically enrolled into the RCO program. Providers will have a choice in determining whether they would like to contract with an RCO and/or continue to provide FFS services to non-RCO clients. It may be that RCOs may offer a FFS contract to providers for RCO clients.
7/24/14	**Q173. Will the State consider the use of a phased-in effectuation of RCO beneficiaries?** A173. The State does not anticipate use of a phased-in effectuation of RCO beneficiaries within a region.
7/24/14	**Q174. Will limits on physician visits, hospital days, dialysis and other services continue under the RCOs? If not, will the removal of such limits be accounted for in the development of the RCOs' capitation rates?** A174. Capitation rates are based on current expenditures and policy. The RCO may choose to relax limits but will not be accounted for in the development of the capitation rates.
7/24/14	**Q175. What is a realistic timeframe to expect CMS to decide Alabama Medicaid Agency's 1115 waiver?** A175. Alabama Medicaid Agency is expecting a decision within 12-18 months from the submission date. The waiver was submitted on May 30, 2014.
7/24/14	**Q176. Can PCNA use its reserve to invest in a Regional Care Organization and thereby become a risk bearer?** A176. After reviewing ACA Section 2703, the SPA related to Health Home Services and the active PCNA RFP, there is no obvious way for Medicaid to approve the use of reserve PCNA funds for a capital contribution to a regional care organization. The State provides payment to the PCNA "for the provision of health home services." Health home services are broadly defined by category in the ACA, but the SPA goes further to give specific meaning to each of the six categories of services. If any PCNA feels strongly that this use of reserve funds should be considered acceptable to Medicaid, it would be helpful to hear its justification.
10/7/14	**Q177. Has AMA made a decision about pharmacy?** A177. Pharmacy will be carved out of the RCO Program.
3/26/15	**Q178. We are a physical, occupational and speech therapy group who works under the referral of the PMP. How will the new RCO changes apply to us?** A178. PT/OT/ST services will be covered by the RCOs. Most likely the referral process will not change, but will be conducted in a method compliant with state law. Providers will need to contract with RCOs to provide covered services to RCO enrollees after October 1, 2016. Claims for services provided to Medicaid recipients outside of the RCO system (e.g. foster child) will be filed as usual to Medicaid through HP on a fee-for-service basis.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
3/26/15	**Q179. I've been asked to find a total (by county) of members eligible for the members eligible for the RCO. Do you have any reports that would have this information available? For reference, I have a copy of the AMA Annual Report (year 2013, p.20) that has a listing of membership by county, but from my understanding there are additional aid categories listed in this report breakdown that will not be RCO eligible. If you could touch base with me and/or direct me in the right direction to find this out, I would greatly appreciate it.** A179. This report is under development. When complete, the report will be made available on the AMA website.
4/03/15	**Q180. I saw on Page 21 of AMA's application to CMS (http://medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3.3_1115_Waiver.aspx) that RCOs are to create proposals that will show which care initiatives they want to pursue ("Each participating RCO, hospital, or provider must develop a DSRIP Proposal, consistent with the DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement". Has each RCO submitted a DSRIP Proposal yet, and if so, where can I find them?** A180. A critical part of Alabama's waiver request its request to use federal funds that are expected to be saved over the five years of the waiver to support the state's transition to managed care. Funds provided through a Delivery System Reform Incentive Program (DSRIP) must be linked to specific objectives and outcomes a and be used to promote community-level initiatives that focus on system reform. The agency is in discussions with the federal government regarding if this kind of methodology will be approved or not.
4/03/15	**Q181. We are a General Surgeons office who is affiliated with one hospital but have patients from outlying counties which will be in different regions. Do we need to sign up with a RCO in each region our patients are located in and will we be able to file for patients from other regions?** A181. Effective October 1, 2016, about two-thirds of all Medicaid recipients will be enrolled in the RCO program. Individual recipients will only be enrolled in one RCO. Being paid for services rendered to a given client will require a contract with that recipient's RCO. If you see recipients from multiple RCOs, payment will hinge on a contract with each RCO; however, the decision to sign with one or more than one RCO, is yours.
04/03/15	**Q182. Is it a requirement to sign up for the RCO?** A182. Providers are free to sign a LOI and ultimately contract with one or more RCOs both within and outside the region in which they are physically located. However, in order to be reimbursed for RCO-contracted services on or after October 1, 2016, providers must contract with one or more RCOs. Services outside of the RCOs will continue fee-for-service for most providers.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
4/03/15	**Q183. How do you sign up?** A183. It is up to the provider to contract with the RCOs. A list of RCO provider enrollment contracts is available on the Agency's website at www.medicaid.alabama.gov under Newsroom > Regional Care Organizations.
4/03/15	**Q184. When is the deadline to sign up and is there a payment penalty if you do not sign up?** A184. The decision to contract with an RCO rests with the provider. However, in order to be reimbursed for RCO-contracted services on or after October 1, 2016, providers must contract with one or more RCOs. Services outside of the RCOs will continue fee-for-service for most providers.
4/14/15	**Q185. I work with multiple pediatric providers and would like to ask the questions specific to the chronic conditions listed below: Are there any age ranges attached to these chronic conditions and are all of the chronic conditions considered for pediatric patients Ages 0 – 20?** Asthma Diabetes Cancer COPD HIV Mental Health Conditions Substance Use Disorders Transplants Sickle Cell BMI over 25 Heart Disease Hepatitis C A185. There is no age range that is attached to these chronic conditions.
4/14/15	**Q186. Would it be possible to set-up a meeting with someone at the agency to discuss the possibility of working with the State to develop favorable pricing on stop-loss that would benefit all of the RCOs? This would give the agency control of the risk mitigation and provide an even stop-loss product for all participating in the program.** A186. The RCOs will be bearing the risk therefore you would need to discuss your services directly with them.
6/3/15	**Q187. Can the RCOs exclude any physicians?** A187. No, there is a legal mandate that RCOs work with any willing provider who contracts with Medicaid. See SB 340, page 18, section 9.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
6/3/15	**Q188. When will providers be expected to sign these contracts?** A188. It is expected that Contracts be signed in the Spring of 2016.
12/01/15	**Q189. Has the list of QA measures to incentivize been chosen?** A189. We are still working on choosing the list of measures to incentivize. We hope to have the list completed in the next several weeks. The list will be posted on the RCO site of the Medicaid web page.
12/02/15	**Q190. Do patients have to be sent to those hospitals listed?** A190. All hospitals will have an opportunity to participate.
12/03/15	**Q191. Do we have to accept other current or newly eligible Medicaid patients?** A191. PMPs determine their panel size.
12/03/15	**Q192. Will processes such as prior authorization have a uniform process will there be 11 different processes?** A192. Certain processes will be uniform based on basic requirements stated in the full-risk contract, however, each RCO can make customized changes for such processes.
12/07/15	**Q193. What is the incentive for the patient to join an RCO or Health Home if they can just stay in Patient 1st?** A193. The incentive for patients with chronic conditions to join a Health Home include comprehensive care management, care coordination services and transitional care services. When RCOs go live October 1, 2016, instead of being enrolled in the Patient 1st Program, most Medicaid patients must be enrolled in an RCO.
12/07/15	**Q194. Do all the providers in the group need to sign up with Patient 1st or is it enough if only some are signed up?** A194. All providers in the group will need to complete an Individual Patient 1st Enrollment Agreement.
12/07/15	**Q195. Will Family Planning Services and Dental Services remain a "carve-out"?** A195. Yes, family planning and dental services are not services provided in an RCO.
12/07/15	**Q196. Will there be no direct filing of claims to Medicaid?** A196. Medicaid will continue to pay fee-for-service claims for recipients that do not participate in the RCOs.
12/07/15	**Q197. Will there be a VFC program for vaccines?** A197. The Vaccines for Children (VFC) Program currently falls outside of Medicaid and will fall outside of the RCOs. The administration rate will be negotiated between the provider and the RCO.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
12/07/15	**Q198. What constitutes as Emergency OON services?** A198. It's our expectation that RCOs and their recipients use their assigned RCO. When that is not possible due to a true emergency, the RCO will need to establish a policy and relationship with other RCOs to address the emergency needs of the recipient.
12/07/15	**Q199. Will Medicaid coverage/limitations change once RCOs are underway?** A199. Minimum limitations will stay the same but the RCOs can opt to increase those.
12/07/15	**Q200. How are claims filed?** A200. Through the RCO.
2/15/16	**Q201. Within the RCO Contract Section 13.1.1, Table 13-1, Requirements for Maternal Health Care Coordination reference completing specific screenings within 5 days of the woman's application for Medicaid eligibility. Could you clarify how we would receive that date? It seems as if this wording may need to be changed, due to the fact that the RCO will not have this information until well past the 5 day requirement.** A201. The contract language is currently being updated to clarify that the Contractor must conduct a Maternal Health screening for all pregnant Enrollees within five (5) Business Days of notification of the pregnant woman's enrollment with the Contractor. This means that if the RCO is notified on 1/15 that the member selected their RCO, the screening needs to be complete by 1/20.
2/15/16	**Q202. Do we need to report on providers whose information doesn't match what we have in our system?** A202. Please supply the correct provider information along with the old information provided by the Agency on the SDN reporting template. Please send this to Drew Nelson at: Drew.Nelson@medicaid.alabama.gov.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
2/15/16	**Q203. As indicated in Section 10.6.1.12 of the RCO contract, the Contractor must cover Mental Illness Rehabilitative Services provided by Community Mental Health Centers who are 310 Boards that are certified by and under contract with DMH . The Contractor must use Community Mental Health Centers (CMHCs) that meet the criteria defined in Alabama Medicaid Administrative Code Rule 560-X-47-.03, Chapter 580-1-2 Administrative standards for 310 Boards, Chapter 580-2-9.01 , and the DMH Contract Services Delivery Manual (CSDM).** **We need guidance as to how to identify these CMHCs to exclude. A listing of the Community Mental Health Centers in Region A that should be excluded from coverage by RCO would be sufficient.** A203. The Medicaid Provider File is the best way to identify the Centers which provide Mental Illness Rehabilitative Services. The provider type is 11 and the specialty is 111. These are the only providers credentialed to provide these services.
2/15/16	**Q204. May a member of our RCO Provider Standards Committee also be a member of our RCO board of directors?** A204. Yes, a member of the Provider Standards Committee may also be a member of the Board of Directors
2/15/16	**Q205. Please provide guidance on AMA's expectations for PHI disclosures for minor children enrolled in the RCO. Since RCO enrollees will all be individually enrolled (no family policies), how will the RCOs know who a child's caregiver/parent is so that we are sure not to share PHI with individuals not authorized? Will parents/caregivers be identified in the enrollment records sent to the RCOs? If so, this would assist the RCOs. If not, should the RCOs just use reasonable precautions to ensure it is not sharing PHI with unauthorized individuals. For example, if an individual contacts an RCO to obtain PHI about a child, can it share the information if the individual is able to correctly provide individually identifiable information about the child (such as the child's name, date of birth, enrollee ID#, and Medicaid ID)?** A205. Yes, parents/caregivers will be identified in the enrollment records as long as they are identified as head of household in the enrollment records. However, each RCO should have policies and procedures in compliance with Federal Privacy and Security laws (HIPAA) that guide staff as to what information, with whom, and under what circumstances PHI can be shared. Further, in compliance with HIPAA, all staff should have training on these policies and procedures as applicable to her or his role in the RCO.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
2/15/16	**Q206. There are two quality measures (numbers 8 and 37) that require the RCO to provide information on separate lines of business:** **#8 - This measure is used to assess the percentage of members 12 months to 24 months, 25 months to 6 years, 7 years to 11 years and 12 years to 19 years of age who had a visit with a primary care practitioner (PCP). The organization reports four separate percentages for each age stratification and product line (commercial and Medicaid).** **#37 - This measure is used to assess the percentage of members 20 to 44 years, 45 to 64 years, and 65 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each age stratification and product line (commercial, Medicaid and Medicare) and a total rate.** **We are wondering whether these measures might include typos since the RCOs provide neither commercial nor Medicare services? The RCOs will not be able to report on lines of business outside its RCO population.** A206. No, these are HEDIS measures. The Agency is only assessing Medicaid data.
2/15/16	**Q207. May the RCOs have provider contract templates under review by the agency while the provider standards are in the publication phase?** A207. Generally, no, but this will depend on how the provider standards are incorporated into the provider contract. If the standards are incorporated by a separate exhibit which can be amended independent of the contract template, then yes.
2/15/16	**Q208. Per the RCO contract section 19.4, PMPs and hospitals are required to have a connection to Alabama One Health Record or another State agency approved HIE. Please provide more details for this. Does this mean sending or receiving data?** A208. For the first 2 years of the contract, Alabama Medicaid Agency considers both DIRECT Secure Messaging (DSM) and connections to One Health Record as bi-directional capabilities of data exchange within the scope of the contract.
2/15/16	**Q209. Will the agency please consider publisher an RCO's provider standards on its website? This would be a central, logical place for Medicaid providers to check for such information. We feel it is the most appropriate mode of publication.** A209. Yes, the Agency will consider it. However, the RCOs would be expected to publish the standards on their own respective websites as well.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
2/15/16	**Q210. Can the Agency please clarify if all requirements listed in the RCO contract apply not only to the Contractor's (RCO's) Subcontractor, but also to the Subcontractor's contractors? The contract definitions of "Subcontract" and "Subcontractor" seem at odds with each other.** A210. Yes, they would apply.
2/15/16	**Q211. RCOs are required to indicate board certification in the provider directory; however, the provider extract does not supply the board specialty, only the license number of the board. Will Alabama Medicaid provide the board specialty?** A211. The RCO will need to collect this information from the individual providers in its network.
2/15/16	**Q212. Is a monthly capitation payment received in an Enrollee is in the "Delivery" aid category? Does a pregnant member have to be in a specific aid category for the kick payment to be received?** A212. The AMA does not expect the RCOs to mail EOBs to members.
2/15/16	**Q213. Please confirm that the AMA does not expect the RCOs to mail EOBs to members?** A213. The AMA does not expect the RCOs to mail EOBs to members.
2/15/16	**Q214. There is currently a 14-day office visit benefit limit for Medicaid members. Does this mean that all of specialties have to total 14, or is it 14 per specialty type?** A214. The limitation of 14 office visits per year applies across specialties
2/15/16	**Q215. Is it possible to get a list by service - not by code - of prior-authorizations by Medicaid?** A215. Yes, you will be receiving these files within the next 2 weeks.
2/15/16	**Q216. On the fee schedule, would it indicate that there are certain recipients eligible for that service? For example, the insulin pump isn't eligible for people ages 21 and older.** A216. The Agency is working on adding a column to show any age restrictions.
2/15/16	**Q217. If PRCOs submit their prior-authorization policies (which differ from the Agency's policy) during Readiness Assessment, does it mean that the policy is approved, or does the Agency have to approve them through another channel?** A217. Yes, the policy is considered approved if it is approved during the Readiness Assessment process.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
2/15/16	**Q218. Will the eligibility and enrollment process be the same for Maternity recipients after Oct. 1? In regards to encounter data, do you envision that continuing after the RCOs go-live?** A218. Yes, the eligibility and enrollment process will be the same. Additionally, the contract language is currently being updated to clarify that the Contractor must conduct a Maternal Health screening for all pregnant Enrollees within five (5) Business Days of notification of the pregnant woman's enrollment with the Contractor. This means that if the RCO is notified on 1/15 that the member selected their RCO, the screening needs to be complete by 1/20. Encounter data will still be required.
2/15/16	**Q219. For caregivers and family members, will AMA share the names of the authorized individuals that can speak on behalf of minors or will the RCO have to develop its own policy?** A219. Yes, parents/caregivers will be identified in the enrollment records as long as they are identified as head of household in the enrollment records. However, each RCO should have policies and procedures in compliance with Federal Privacy and Security laws (HIPAA) that guide staff as to what information, with whom, and under what circumstances PHI can be shared. Further, in compliance with HIPAA, all staff should have training on these policies and procedures as applicable to her or his role in the RCO.
2/15/16	**Q220. How often are the fee schedules updated, and is there a field that lets the RCO know when the last update was? Is there a regular schedule for updates? Will the DME fee schedule be released?** A220. Fee schedule updates are published on AMA's website, and the date is included of when the update occurred. The Agency is currently looking at the frequency of each schedule's updates and the processes around how those updates occur as well as which information is included. The Agency is looking to improving this process and will provide an update to all of the RCOs in a couple of weeks. The most recent DME fee schedule can be located on the Agency's website at the following link: http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx.
2/15/16	**Q221. Will changes to the referral process have to be approved by the Agency?** A221. The Agency must review and monitor every RCOs' referral process. The RCOs' referral process can be less restrictive, but, if it's more restrictive, the Agency has to approve it.
6/6/16	**Q222. Can a PMP serve as Medical Director for two Regional Care Organizations if he serves recipients in both regions? Can this PMP also serve on the Provider Standards Committee in two different Regions?** A222. Yes, if the PMP serves recipients in both regions, he can serve as Medical Director and on the Provider Standards Committee in those two respective regions.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
6/6/16	**Q223. We expect that majority of members will voice their grievances orally and RCO can resolve orally. Can we resolve issues in this way?** A223. The response to the grievance by the Contractor shall be in writing and fully explain the decision reached as to each part of the grievance presented and the reasons for the decision.
6/6/16	**Q224. In reference to section 8.11 Enrollee Handbook, is it required that a Enrollee Handbook be issued to each individual enrollee or can an Enrollee Handbook be sent per household? Can we apply the language for Provider Directories to Enrollee Handbooks? (8.12.2 The Contractor must provide new Enrollees the most current complete listing of Participating Providers in hardcopy, including hardcopy updates to such listing. If more than one new Enrollee resides at the same address, the Contractor may initially provide one listing per household and provide additional copies upon request.)** A224. One enrollee handbook should be sent to each head of household for recipients. The person who is the Medicaid "payee" (Head of Household) of the child should receive the handbook for minor children. Where there are more than one adult participant at a single address listed as a separate payee/head of household (single adult) they should receive their own separate handbook. Example: Mother has three children and she is listed as "payee" (head of household) and has an adult sister on SSI (who is her own payee/head of household) at the same address. Two handbooks should be issued (One for each head of household). No, the provider directory language cannot be used for the Enrollee Handbook.
6/6/16	**Q225. Come Oct 1st, will the state continue to identify which patients are Health Home eligible or will the RCO be tasked with HH assignment identification from their assigned pool? How will the RCO's know what patients are HH eligible?** A225. The RCOs will be responsible for identifying Health Home recipients starting October 1st. The RCOS will be screening the recipients according to the Health Home requirements as outlined in the RCO contract.
6/6/16	**Q226. Will the Health Homes need to complete Health Home agreements for new primary care providers or will the RCO contracts trump needing HH agreements?** A226. Provider contracts with the RCOs would be sufficient.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
6/6/16	**Q227. Come Oct 1st, if a women who did not previously qualify for Medicaid becomes pregnant and now qualifies for RCO services, will that new pregnant Medicaid recipient be auto assigned to an RCO or will she also have choice in picking her RCO? And how will we be notified of this new member and the fact that she is pregnant.** A227. the new member will be given the choice to enroll with an RCO through the Enrollment Broker. If she does not make an active selection through the Enrollment Broker, then the Agency will auto-assign her to an RCO. Many pregnant women can be identified by her aid category submitted through the 834 eligibility file.
6/6/16	**Q228. If the RCO receives the eligibility file and they see new enrollees, by when do they have to send enrollment packet? Does the "within 15 days the effective date" language mean 15 days prior or 15 days after?** A228. In accordance with Alabama Medicaid Administrative Code Rule 560-X-62-.21, the RCO should mail the enrollment packet within 15 days of notification of new enrollees. For October 1st enrollment, RCOs will receive files around September 1st and should send packets by September 15. After program go-live, the enrollment notification will be sent a few days prior to the enrollment effective date. RCOs will be required to send packets within 15 days of notification.
6/6/16	**Q229. If through the course of initial contracting, ongoing provider relations or claims discussions we are made aware of updates to provider information, is there a process that we should provide that information back to the State to update the State provider file?** A229. If through the initial contracting phase you RCO identifies a provider at a new address, please provide that information in the Agency's SDN spreadsheet on a new tab (please notate both the incorrect Agency information and the updated information). For ongoing updates, please ask the provider to submit an update to HPE Provider Enrollment.
6/6/16	**Q230. In the RCO draft Contract, section 9.8, states: "…Provider bordering Alabama, within thirty (30) miles of the Alabama state line, may be included within the Contractor's Provider Network. All other out-of-state Providers should be enrolled only for the treatment of emergent care or for services not otherwise available in-State…" Does this mean that a provider must have bricks and mortar within the State of Alabama or within 30 miles from the state line? What if there is a DME provider that is available for mail services that is currently providing care to Medicaid recipients, can they be considered for contracting with the RCO even though they are located outside the area?** A230. Providers must have physical location within the border limits defined by the contract. Please refer to Medicaid Provider Manual Chapter 14 for DME Enrollment policy.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
6/6/16	**Q231. How will my office know what and where to pre-cert for MRI and Surgery for each RCO?** A231. The RCOs you contract with will give you provider manuals that include prior authorization information.
6/6/16	**Q232. For provider training and the requirement for RCOs to train them "within 30 days," is that requirement within 30 days of the RCO start date? And by "within," do you mean 30 days after start date or 30 days before start date?** A232. The Contractor must provide training to all Participating Providers and their staff regarding the RCO Program and special needs of Enrollees within thirty (30) Calendar Days of a Provider joining the Contractor's Provider Network.
6/6/16	**Q233. What is the Agency's expectation of the RCO regarding return mail? Is the RCO allowed to update its system with a new address identified using other sources such as national change of address database, a forwarding address provided by USPS on the return mail item or public records search or is the process for us to notify the Agency of the return mail via the alert file and wait on a new address to be received on the 834 file?** A233. Each code should have a limit. The Agency is in the process of updating this information. RCOs should alert the Agency if a new addressed is found through the alert report.
9/12/16	**Q234. How can we identify family relationships from the eligibility file? It would be helpful when assigning PMPs and for member outreach.** A234. Per the 834 Implementation Guide that is available on the RCO portal, the family relationship is sent in 2100G. The Medicaid ID for the head of household will be submitted in this loop.
9/12/16	**Q235. How do we get contact information for the RCO groups listed on the network map? I am in region A and would like to contact the organization about signing contract.** A235. Please visit the following link for all of the RCOs' contact information: www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Topics_Issues/2.7.3_RCOs/2.7.3_Admin_Contacts_ProbRCOs_3-15-16
10/18/16	**Q236. There do not appear to be any codes available for swallowing/feeding therapy, is this the intent of the policy? Specific codes are 92526, 92610, 92611, 92612, 92614, 92616.** A236. All of the codes are covered and are listed in the Hospital OP Fee Schedule Only PC 92610 has the <21 age restriction. All codes are diagnosis restricted.

Miscellaneous	
Date Added/ Revised	**Questions and Answers**
10/18/16	**Q237. Is there a tentative timeline as to when Chapter 23 of Alabama administrative code will be updated?** A237. The Agency will be updating appropriate sections of the Alabama Administrative Code (Chapter 23) and the Alabama Medicaid Agency State Plan related to Hospital Reimbursement changes in the near future.
10/18/16	**Q238. Please confirm that the health homes will be able to access and use RMEDE as our documentation software until such time the PRCO's become fully certified RCO's.** A238. Yes, RMEDE will be available until the RCO go-live date.

RCO	
Date Added/ Revised	**Questions and Answers**
12/07/15	**Q239. Are pathology labs able to be considered as providers for this new program?** A239. Yes, according to the Service Delivery Network Requirements Rule (560-X-62-.12), laboratory service facilities must be included in the Regional Care Organization's provider network.
12/07/15	**Q240. Are covered services paid under the Medicaid Fee Schedule or will there be another Fee Schedule for these services?** A240. Please visit the FAQ list on the Alabama Medicaid Agency website: http://medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Topics_Issues/2.7.3_RCOs/2.7.3_RCO_FAQs_10-20-14.pdf
12/07/15	**Q241. Is there a different fee schedule for the physician's participating in the RCOs?** A241. Please see the Administrative Code Rule Fee-For-Service Reimbursement Rates (560-X-62-.10) (http://medicaid.alabama.gov/documents/5.0_Resources/5.2_Administrative_Code/5.2.1_Agency_Rules/5.2.1.2_Proposed_Rules_2014/5.2.1.2_Rule_62-10_filed_5-20-14.pdf)"
12/07/15	**Q242. Will the RCOs require authorizations?** A242. The RCO may require Enrollees and Providers to obtain authorization for Covered Services from the RCO, except to the extent prior authorization is prohibited by the Agency.
12/07/15	**Q243. Will most patients be required to select one of the RCOs?** A243. The patient assignment in the Regional Care Organizations will be based on the patient's residence.
12/07/15	**Q244. How will reimbursement flow from the RCOs for revenue cycle management?** A244. For RCO-covered services, providers will submit claims directly to the RCO (or the RCO's subcontractor). The RCO will provide instructions regarding how to submit claims for payment. The RCO will be responsible for processing the claims and paying providers based on the contracted rate between the RCO and the provider.
12/07/15	**Q245. If there is more than one RCO within a region, will one RCO eventually win the bid for that region, or will they share the patient base?** A245. There are a total of 11 Probationary RCOs in 5 Regions; 2 RCOs have been established in Region C that will share the population of recipients and provide services through their contracted providers. A recipient will only be assigned to one RCO; the recipient may also choose one RCO over another. To ensure that your facility and clinics can see all the recipients within Region C and receive proper payment, a contract with both RCOs within the region will be required.

RCO	
Date Added/ Revised	**Questions and Answers**
12/07/15	**Q246. Will prior authorization requirements for claims be different than they are today? Will more or less services require a prior authorization? How will each RCO process prior authorizations?** A246. The RCO will be responsible for prior authorization requirements unless prohibited by the Agency.
12/07/15	**Q247. Is substance abuse carved our of the RCO Program?** A247. Yes, substance Abuse is currently carved out of the RCO program.
12/07/15	**Q248. Is the hemophilia program remaining fee-for-service?** A248. My understanding is that the current factor program billed through pharmacy will remain fee for service, and not be included in the RCO.
12/07/15	**Q249. Do infusion services need to be a part of the RCO system?** A249. Infusion services billed through HCPCS are currently billed through the DME NPI, not the pharmacy NPI. The infusion services billed through the DME NPI will be an RCO-contracted service.
2/15/16	**Q250. Will the RCOs contract with the Department of Public Health to utilize its case managers to provide care coordination services?** A250. RCO's can choose how they will provide this service. It is up to each individual RCO as to whether or not they will contract with Alabama Department of Public Health for care coordination services.
2/15/16	**Q251. Does the patient/patient's physician have freedom of choice of DME provider assuming the DME provider is enrolled in good standing with the patient's RCO?** A251. Yes.
2/15/16	**Q252. Can the RCO coerce/force/incentivize a patient to use a specific RCO?** A252. No.
2/15/16	**Q253. When the RCOs are fully implemented, will they act like managed care plans? Will the claims then go directly to the RCOs instead of fee for service Medicaid?** A253. The RCO will act as managed care plans and claims will go to the RCO for only services that are carved into the RCO Program.
2/15/16	**Q254. How will independent RHC's will be compensated under RCO's coming October 2016?** A254. The RCO will pay the RHC or FQHC based on the current physician fee schedule. Medicaid will make a wraparound payment to the provider for the difference in the payment made by the RCO and the provider's encounter rate.

RCO	
Date Added/ Revised	**Questions and Answers**
2/15/16	**Q255. Currently, Medicaid recipients that are pregnant go thru care coordinators in programs such as Best Start, Steps Ahead, etc. will those programs still exist or will pregnancy be managed in a different way?** A255. Those programs will not exist. The RCO will be required to manage the program.
2/15/16	**Q256. Prior to 10/1/16, will the Agency communicate to the Medicaid members which RCO they have selected or have been auto assigned to? If so, what date is this expected to occur?** A256. The members will either select or be assigned by September. Between July and the end of August, enrollees can pick their RCO, and, at the end of August, they will be assigned.
2/15/16	**Q257. As a provider, if we are already enrolled in the Medicaid program would we need to set up a separate RCO account to enroll in the RCO network for our county?** A257. You may not need to setup a separate account, but it is up to the RCO's you contract with. It is up to the provider to contract with the RCOs. A list of RCO provider enrollment contracts is available on the Agency's website at www.medicaid.alabama.gov under Newsroom > Regional Care Organizations. Providers are free to sign a LOI and ultimately contract with one or more RCOs both within and outside the region in which they are physically located
2/15/16	**Q258. Does authorization for advanced imaging change with the implementation of RCO's, or will they continue to go through EviCore (formally MedSolutions)?** A258. Each RCO will develop their own prior authorization policies to be approved by the Agency. For more specific answers, please contact the RCO(s) you have contracted with.
6/6/16	**Q259. Please confirm that no additional credentials verification beyond Medicaid participation and not being excluded from Medicare or Medicaid is required by the RCO.** A259. Yes, that is correct. Medicaid will retain credentialing. Having said that, the RCOs should remain attuned to whether or not a provider has been placed on the exclusion list.
6/6/16	**Q260. Will the eligibility and enrollment process be the same for Maternity recipients? Will encounter data still be necessary going forward?** A260. Yes, the eligibility and enrollment process will be the same. Additionally, the contract language is currently being updated to clarify that the Contractor must conduct a Maternal Health screening for all pregnant Enrollees within five (5) Business Days of notification of the pregnant woman's enrollment with the Contractor. This means that if the RCO is notified on 1/15 that the member selected their RCO, the screening needs to be complete by 1/20. Encounter data will still be required.

RCO	
Date Added/ Revised	**Questions and Answers**
6/6/16	**Q261. For caregivers and family members, will AMA share the names of the authorized individuals that can speak on behalf of minors or will the RCO have to develop its own policy?** A261. Yes, parents/caregivers will be identified in the enrollment records as long as they are identified as head of household in the enrollment records. However, each RCO should have policies and procedures in compliance with Federal Privacy and Security laws (HIPAA) that guide staff as to what information, with whom, and under what circumstances PHI can be shared. Further, in compliance with HIPAA, all staff should have training on these policies and procedures as applicable to her or his role in the RCO.
6/6/16	**Q262. Will changes to the referral process have to be approved by the Agency?** A262. The Agency must review and monitor every RCOs' referral process. The RCOs' referral process can be less restrictive, but, if it's more restrictive, the Agency has to approve it.
6/6/16	**Q263. If someone is in a RCO, will they be handled like individuals who are in patient first? With the patient first cases the Nursing Home has to get them out of patient first in order to get paid, especially if the resident is from another county.** A263. The Patient 1st program will end on October 1, 2016. If an RCO member enters the Nursing Home for a short term stay (90 days or less) they will remain in the RCO and the RCO will be responsible for payment of those services covered by the RCO. Nursing homes will continue to bill directly to Medicaid since this service is not covered by the RCO. For a long term stay (over 90 days), the client will no longer be assigned to an RCO.
6/6/16	**Q264. If someone is in a RCO and is admitted to a Nursing Home for a temporary illness with the intent of returning home, it is likely that he/she will have to apply for Medicaid in the Nursing Home or, for the SSI only population, apply for the 90 day stay exception with SSI. Will the Nursing Home have to do ANYTHING in relation to the RCO or just simply assist the resident, when appropriate, with applying for Medicaid or the 90 day stay exclusion?** A264. The Nursing Home does not have to do anything in relation to the RCO; only assist the resident with the application.
6/6/16	**Q265. If someone is in a Health Home with the RCO and an illness causes them to need temporary Nursing Home care, will the RCO Health Home Case Manager make arrangements for Nursing Home care and will the RCO or Medicaid pay the Nursing Home?** A265. The RCO Health Home Care Coordinator will assist in making arrangements for Nursing Home care; Medicaid will reimburse the Nursing Home.

RCO	
Date Added/ Revised	**Questions and Answers**
6/6/16	**Q266. Nursing Home's have been getting requests to enroll with RCO's. Should they enroll with the RCO and what would be the reason for doing so?** A266. LTC services are not included in RCOs. A Nursing Home should not be getting a request to enroll with an RCO.
6/6/16	**Q267. We have a number of situations where an individual from one county goes to a Nursing Home in another county which is not in the individual's RCO area (example: Perry County resident goes to a Nursing Home in Dallas County). That resident is assigned to a RCO physician in Perry County. He/she will be using a physician which serves the Nursing Home. What does the resident have to do in relation to the RCO to insure that he/she can be seen by the physician serving that Nursing Hp,e?** A267. For a short term stay (90 days or less) they will remain in the RCO and the RCO will be responsible for payment of those services covered by the RCO; except for Nursing Home services. Each RCO is responsible for providing services to a short-term stay client through a physician. If the physician is not contracted with the RCO the recipient is assigned to; the physician will need to contact the RCO to discuss payment arrangements. For a long term stay (over 90 days), the client will no longer be assigned to an RCO.
6/6/16	**Q268. If the Nursing Home placement will be coordinated by the RCO but PAID by Medicaid, would a contract with the RCO be required in order for the Nursing Home to take that patient and be paid by Medicaid.** A268. A contract would not be required
6/6/16	**Q269. If a care coordinator through the RCO is making arrangements for Nursing Home care and will continue to follow the patient during the Nursing Home stay will a contract with the RCO be required in order for the Nursing Home to be able to take the resident, even though the RCO will not be paying for the resident's care.** A269. A contract would not be required
6/6/16	**Q270. For the individual who receives SSI and Social Security with no medicare and who is in a RCO enters a nursing home for a long term stay to exceed 90 days, the usual process to continue Medicaid eligibility for such an individual would be to apply for Medicaid through the District Office. Will the RCO affect this process in any way?** A270. The RCO will not affect this process

RCO	
Date Added/ Revised	**Questions and Answers**
6/6/16	**Q271. Whether an individual is simply a RCO member or one of the patients who is being managed by the RCO more closely due to certain medical conditions, if he/she enters a Nursing Home does he/she have a choice to remain in or leave the RCO upon admission to the Nursing Home and, if so, how does the individual withdraw from the RCO?** A271. The RCO member is locked-in to their RCO unless the stay exceeds 90 days
6/6/16	**Q272. An individual enters a Nursing Home which is outside his/her current RCO region. Does the resident/Nursing Home have to take any action to ensure that the individual can receive uninterrupted Medicaid services?** A272. Neither the RCO or the Nursing Home will have to take any action
6/6/16	**Q273. Our clinics are located in REGION B; however, our patients come from not only Region B but from other RCO regions within the state. Therefore, it is our understanding we would need to contract with the specific REGION where our patients originate from. Since Alabama Healthcare Advantage has a presence in all five regions, would we have to contract once with the RCO or five separate times? The same question applies to Alabama Community Care, which also appears to have a presence in two regions.** A273. Each RCO is a separate entity. Therefore, you should contract with each RCO in each region that you want to receive patients from.
6/6/16	**Q274. Speakers stated that referrals, authorizations, etc. would be no more restrictive than they are now; also stated RCOs would have their own guidelines When we contract with an RCO, are they allowed to add anything in their contract or have "own guidelines" which would create a greater requirement for authorizations or referrals?** A274. The Agency must review and monitor every RCOs' referral and authorization process. The RCOs' referral and authorization processes can be less restrictive, but, if they are more restrictive, the Agency has to approve them. After they receive Agency approval, RCOs cannot change the language of their contracts without going through the approval process again.

RCO	
Date Added/ Revised	**Questions and Answers**
6/6/16	**Q275. There has been such a gap in services for children with social - emotional issues requiring mental health services/intervention. How will RCOs provide services to children with social-emotional issues requiring mental health services or medical intervention?** A275. It is the role of the Care Coordinators from each RCO to ensure that children with social-emotional issues receive all necessary services through linkages to community mental health centers, specialty clinics, and other medical facilities and agencies. RCOs will be responsible for seeing that enrolled children receive necessary health care.
6/6/16	**Q276. Are the RCO's under any obligation to contract with DME's? Or, is it possible for an RCO to refuse to contract with a DME?** A276. In accordance with the contract, RCO's must contract with any willing hospital, doctor or other provider to provide Covered Services in the Region if the Provider is willing to accept the payments and terms offered comparable Providers. All Providers shall meet licensing requirements set by law, shall have a Medicaid provider number, and shall not otherwise be disqualified from participating in Medicare or Medicaid.
6/6/16	**Q277. How do I contact the RCO's to become a provider for them? There was a list at one time of the probationary RCO's and I called and left messages and no one responded, now I cannot find their contact information.** A277. The contact information can be found at the following link: http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Topics_Issues/2.7.3_RCOs/2.7.3_RCO_Provider_Enrollment_Contacts_3-11-16.pdf.
6/6/16	**Q278. Is it mandated for providers to participate/enroll with RCOs to bill the services rendered?** A278. No; however, failure to do so would mean you would not be eligible for payment for services provided to the approximately 2/3rds of the entire Medicaid population. For more information, please visit the following link: http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3_Regional_Care_Organizations.aspx
6/6/16	**Q279. Could you tell me if there is a form or an electronic application of some type that DME providers need to complete to be able to be registered/certified by Medicaid specifically to be able to do business with and receive reimbursement from the RCO's?** A279. Yes, you must enroll electronically with Medicaid first and can do so at the following link: http://medicaid.alabama.gov/CONTENT/8.0_Contact/8.2.5_Provider_Enrollment.aspx.

RCO	
Date Added/ Revised	**Questions and Answers**
6/6/16	**Q280. Will we be receiving a list of hospitals and which RCO's that they have contracted with? We service several hospitals in different districts.** A280. No, the Agency will not be providing this information. Please contact the RCOs to find out which hospitals are in their networks. As RCOs contract with hospitals and other providers, they are responsible for posting this information on their respective websites.
6/6/16	**Q281. What will be the process for members to switch RCOs once they are assigned?** A281. A member can change at any time if they have a for-cause reason. The member can also switch during the last 60 days of their lock-in period. Otherwise, the member can only change one time within 90 days of their assignment. The member must contact the Enrollment Broker and declare their choice.
8/8/16	**Q282. Will a live demo of the system / product before go-live be required? If yes, what is the date for the demos?** A282. Yes, a demo will be required. A date will be set after determination of the RCO program start date.
8/8/16	**Q283. How will the State notify each RCO when a pregnant woman applies for Medicaid and how will each RCO know that the pregnant woman is assigned to them enable to meet the requirement of the health risk screening within five days of application for Medicaid.** A283. RCOs will not be notified when a pregnant woman applies for Medicaid; RCOs are notified when the pregnant woman is enrolled into the RCO. When a pregnant woman voluntarily selects the RCO or is auto-assigned into the RCO, the state will send an 834 with the woman's information.

8/8/16	**Q284. Aside from the surveys required for CAHPS, here are the contract provisions that our Quality area indicates would require surveys. Please let us know if there are any that the RCO will be expected to conduct out of the following.** **Network Adequacy (9.4.3) – There are lots of standards providers must meet around access and availability.** **Physician Incentive Plans (9.20) – In 9.20.2.6, it mentions "conduct annual Enrollee surveys of Enrollee satisfaction".** **Non-Emergency Transportation (NET) Services: Other than Ambulance (10.10.1.9.5) – In 10.10.1.9.5.2.10, it mentions "Tracking and reporting quality…".** **Care Coordination Program Evaluation (11.10) – Are there survey components to these items that RCOs need to fulfill?** **Home Health Quality (12.3) – In 12.3.1.2, it mentions "Monitor access to care…". In 12.3.1.4, it mentions "Monitor quality and effectiveness of interventions". Are there survey components to these items that RCOs need to fulfill?** **Maternal Health Care Coordination Program Evaluation (13.8) – Are there survey components to these items that RCOs need to fulfill?** A284. Network Adequacy: AMA does not require RCOs to conduct a survey specific to provider network adequacy. However, an RCO may choose to conduct its own provider network adequacy survey as part of its network adequacy monitoring and improvement efforts. Physician Incentive Plans: The annual CAHPS survey meets this requirement. AMA will provide raw CAHPS data to each RCO. Non-Emergency Transportation Services: AMA does not require RCOs to conduct a survey specific to NET services. However, an RCO may choose to conduct its own NET survey as part of its NET monitoring and improvement efforts Care Coordination Program Evaluation: AMA does not require RCOs to conduct a survey specific to Care Coordination program evaluation. However, an RCO may choose to conduct its own Care Coordination program evaluation survey as part of its Care Coordination program monitoring and improvement efforts. Health Home Quality: AMA does not require RCOs to conduct a survey specific to Health Home quality. However, an RCO may choose to conduct its own Health Home quality survey as part of its Health Home monitoring and improvement efforts.

RCO	
Date Added/ Revised	**Questions and Answers**
	AMA does not require RCOs to conduct a survey specific to Maternal Health Care Coordination program evaluation. However, an RCO may choose to conduct its own Maternal Health Care Coordination program evaluation survey as part of its Maternal Health Care Coordination monitoring and improvement efforts.

RCO	
Date Added/ Revised	**Questions and Answers**
9/12/16	**Q285. Please give us more information on how RCOs function during the annual open enrollment period.** A285. There is no annual open enrollment period for all enrollees. There is an annual enrollment period for each enrollee based on when they enter into the program.
9/12/16	**Q286. When is enrollee handbook mailed?** A286. The Contractor must issue and mail, or email at the Enrollee's request, an Enrollee Handbook to a new Enrollee within fifteen (15) Calendar Days of notification of the Enrollee's enrollment with the Contractor.
9/12/16	**Q287. The Alabama Medicaid Manual indicates that providers must take an online SBIRT course via the Alabama Department of Mental Health website: http://www.mh.alabama.gov/SATR/AlabamaSBIRT/Default.aspx. Will the state continue to require physicians complete this training or will the RCO's be required to manage this training?** A287. The state will continue to require physicians to complete this training; however, the RCOs should ensure providers are certified before reimbursing SBIRT services.
9/12/16	**Q288. Sections 23.2.1-23.2.2 of the RCO contract articulate the requirement for the RCO to provide Compliance and FWA training to its employees, providers, and subcontractors. Training content must include compliance with applicable laws, record retention, HIPAA, and FWA information. Must all RCO "subcontractors" receive, and provide for its employees, Compliance and FWA training, even if the subcontractor performs administrative services only? For example, if the subcontractor provides non-emergency transportation services, printing and fulfillment services, or other non-health related services, is Compliance and FWA training still required?** A288. Yes; Sections 23.2.1 and 23.2.2 require the Contractor to ensure at a minimum that all of its Subcontractors receive compliance training. However, the RCO Contract does not require the Contractor to ensure that all of its Subcontractors' employees receive compliance training, although the Contractor may deem it in its best interest to do so.

RCO	
Date Added/ Revised	**Questions and Answers**
9/12/16	**Q289. Can the RCO meet AMA's Compliance/FWA training content requirement if it requires its employees, providers, and subcontractors (as applicable) to complete the Medicare Learning Network (MLN) Compliance and FWA Training (at https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/providercompliance.html)? MLN's Compliance/FWA Training is very extensive and includes the training content required by AMA. This training is already required of all providers and contractors participating in the Medicare program. Allowing this training to satisfy AMA's Compliance/FWA training requirement would greatly reduce the burden and duplication of training for the RCO and its employees, subcontractors, and providers.** A289. No. The training referenced in the question is specifically for Medicare; however, it may be used as guide in developing their Compliance/FWA training.
9/12/16	**Q290. Regarding subcontractors and contractors, who do the fraud waste and abuse training and compliance requirements apply to?** A290. The RCO must ensure at a minimum all its employees, Participating Providers and Subcontractors receive compliance training upon hire or contract execution and annually thereafter.
9/12/16	**Q291. Can you also clarify if Compliance and FWA training is required for subcontractors who just provide administrative services, like printing and mail houses?** A291. Yes; Sections 23.2.1 and 23.2.2 require the Contractor to ensure at a minimum that all of its Subcontractors receive compliance training. However, the RCO Contract does not require the Contractor to ensure that all of its Subcontractors' employees receive compliance training, although the Contractor may deem it in its best interest to do so.
9/12/16	**Q292. Section 10 of the Provider Standards Committee Rule, No. 560-X-62-.09, states that the provider standards committee shall meet at least semi-annually and at other times upon the written request of the chairperson or a majority of the members. Can you please specify if "semi-annually" refers to twice in the fiscal year or twice in a calendar year?** A292. Semi-annually refers to twice in a calendar year.

RCO	
Date Added/ Revised	**Questions and Answers**
10/18/16	**Q293. The Alabama Medicaid Manual indicates that providers must take an online SBIRT course via the Alabama Department of Mental Health website: http://www.mh.alabama.gov/SATR/AlabamaSBIRT/Default.aspx. Will the state continue to require physicians complete this training or will the RCO's be required to manage this training?** A293. The state will continue to require physicians to complete this training; however, the RCOs should ensure providers are certified before reimbursing SBIRT services.
10/18/16	**Q294. Would you be able to provide the reporting requirements for:** **1. Quality Management and Utilization Management** **2. Financial** **3. Grievances and appeals** **4. Solvency and Audit** **Other areas include:** **PMP assignment report (reserve for panel size and status)** **Accessibility analysis (reserve for provider file updates)** **Alternative language (reserve for provider file)** **FQHC and RHC payments (TBD)** **Fraud and Abuse Recipient verification procedure** **Subcontract monitoring report** A294. The Agency is working on these reports and will release them as soon as they are finalized.
10/18/16	**Q295. Please advise if RCO's can use the Edinburg Assessment in addition to the PHQ-2 or PHQ-9 as applicable and for maternity follow up with Edinburg?** A295. Yes, RCO's can use the Edinburg Assessment in addition to the PHQ-2 or PHQ-9.

RCO	
Date Added/ Revised	**Questions and Answers**
10/18/16	**Q296. Is the Agency going to require 1557 of ACA compliance on portals and marketing materials? If the 1557 has to put this all documents, we are hoping to exchange a notice with the Agency stating that we will update all previously approved documents rather than having to resubmit everything.** A296. Yes; 42 C.F.R 438.3(f) in the final managed care rule provides that all contracts with MCOs must comply with all applicable federal and state law and regulations including Section 1557 of the ACA. In addition, 42 C.F.R. 438.100(d) provides the State must ensure that each MCO complies with any other applicable Federal and State laws including Section 1557 of the ACA. Due to this rule change, it will be necessary to re-review certain RCO documents, websites and other materials prior to go-live. Medicaid Communications will provide guidance and a timeline in the near future.
10/18/16	**Q297. We would like to confirm that the requirement for the member to be able to opt-in or opt-out of emails, mailings and texts is referring to non-business critical communications such as email campaigns. Mailings and emails regarding benefits, claims, care coordination, etc. are required correspondence to send to the member. As a result, the members would be unable to opt out of those types of communications.** A297. The Enrollee has the ability to opt out of any electronic form of communication, including phone calls, and request only paper mailings. This would include critical and non-critical business communications. The expectation of the Agency is that all members retain the right to receive any and all communications in written format.
10/18/16	**Q298. Section 10 of the Provider Standards Committee Rule, No. 560-X-62-.09, states that the provider standards committee shall meet at least semi-annually and at other times upon the written request of the chairperson or a majority of the members. Can you please specify if "semi-annually" refers to twice in the fiscal year or twice in a calendar year?** A298. Semi-annually refers to twice in a calendar year.
10/18/16	**Q299. If some of the RCOs' infrastructure is located off site, will on site readiness reviews include these off-site locations rather than trying to demonstrate systems remotely?** A299. The Agency will conduct the review of an off-site location either in person or via WebEx.

RCO	
Date Added/ Revised	**Questions and Answers**
10/18/16	**Q300. We are a DME supplier with several AL Medicaid Enrollees. Do all Medicaid enrollees have to enroll with an RCO before 10/1/16, or can they still have Traditional Medicaid?** A300. Please see the RCO Membership Matrix at the the following link for the draft list of eligibility groups to be included in RCOs, which will begin on July 1st, 2017 pending CMS Approval. http://medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Topics_Issues/2.7.3_RCOs/2.7.3_RCO_Membership_Matrix_1-28-16.pdf
10/18/16	**Q301. I saw on your website that the Agency was seeking to delay the start of RCO implementation past the October 1 start date. Has the Agency decided on a new start date? I didn't see a release about a new start date on the website.** A301. Pending CMS approval, the new start date will be July 1st, 2017. Please visit the following link for more information: http://medicaid.alabama.gov/news_detail.aspx?ID=11768
10/18/16	**Q302. Can you please confirm that there are no mental health transports in the NET reimbursement number?** A302. There are no mental health transports currently provided through DMH in the NET reimbursement number.
11/10/16	**Q303. Is the Agency going to require 1557 of ACA compliance on portals and marketing materials? If the 1557 has to put this all documents, we are hoping to exchange a notice with the Agency stating that we will update all previously approved documents rather than having to resubmit everything.** A303. Yes; 42 C.F.R 438.3(f) in the final managed care rule provides that all contracts with MCOs must comply with all applicable federal and state law and regulations including Section 1557 of the ACA. In addition, 42 C.F.R. 438.100(d) provides the State must ensure that each MCO complies with any other applicable Federal and State laws including Section 1557 of the ACA. Due to this rule change, it will be necessary to re-review certain RCO documents, websites and other materials prior to go-live. Medicaid Communications will provide guidance and a timeline in the near future.

RCO	
Date Added/ Revised	**Questions and Answers**
11/10/16	**Q304. We would like to confirm that the requirement for the member to be able to opt-in or opt-out of emails, mailings and texts is referring to non-business critical communications such as email campaigns. Mailings and emails regarding benefits, claims, care coordination, etc. are required correspondence to send to the member. As a result, the members would be unable to opt out of those types of communications.** A304. The Enrollee has the ability to opt out of any electronic form of communication, including phone calls, and request only paper mailings. This would include critical and non-critical business communications. The expectation of the Agency is that all members retain the right to receive any and all communications in written format.
11/10/16	**Q305. If an RCO elects to switch to a surety bond, whom does the state consider to be an approved institution?** A305. An organization electing to meet its Regional Care Organization Solvency and Financial Requirements through a performance bond must comply with section (3) of the Alabama Administrative Code Rule No. 560-X-62-.16. During the October 1, 2015 Solvency and Financial Requirements demonstration, the Agency provided the Form of the Performance Bond to be issued. Section (3)(a) states: The performance bond shall be issued by an insurer authorized to do business in the State of Alabama and approved by the Medicaid Agency. The Agency has not identified a list of pre-approved insurers, but will base its approval in part on the financial condition and current credit rating of the insurer by a national credit rating agency (A.M. Best Rating Service, etc.) at the time of issuance.
11/10/16	**Q306. If some of the RCOs' infrastructure is located off site, will on site readiness reviews include these off-site locations rather than trying to demonstrate systems remotely?** A306. The Agency will conduct the review of an off-site location either in person or via WebEx.
11/10/16	**Q307. Is it allowable for children referred through EPSDT to visit a free standing PT provider?** A307. Yes, that is correct.

RCO	
Date Added/ Revised	**Questions and Answers**
11/10/16	**Q308. Does multiple surgery reductions apply to Ambulatory Surgery Centers (hospital/freestanding) since they are on a fee-for-service schedule? If so, is it the same as the physician process?** A308. ASC Chapter 9, provider manual: If more than one covered surgical procedure is furnished to a Medicaid recipient in a single operative session, Medicaid pays the lesser of either the submitted charges or the full amount for the procedure with the higher predetermined rate less the copay amount. Other covered surgical procedures furnished in the same session will be reimbursed at the lesser of the submitted charges or at 50 percent of the predetermined rate for each of the other procedures, whichever is lowest. Physicians Chapter 28, provider manual: When multiple or bilateral surgical procedures that add significant time or complexity are performed at the same operative session, Medicaid pays for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure. This also applies to laser surgical procedures. Additional payments will not be made for procedures considered to be mutually exclusive or incidental. Mutually Exclusive procedures are services that cannot reasonably be performed at the same anatomic site or same patient encounter. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g., excision of a previous scar or puncture of an ovarian cyst) are performed during the same operative session, Medicaid reimburses for the major procedure only. CPT defined Add-on codes are considered for coverage when billed with the appropriate primary procedure code. Add-on codes are not subject to rule of 50 percent reduction. Additional information:Please see Alert on attached link re to NCCI edit implementation that affects physicians/ASC and OP hospitals: http://medicaid.alabama.gov/news_detail.aspx?ID=4015 Please see the January 2010 PI article, page 4 on bilateral surgeries and reduction in payment. This affects ASC/OP Hosp and physician claims: http://medicaid.alabama.gov/documents/2.0_Newsroom/2.3_Publications/2.3.7_Provider_News/2.3.7_10_January.pdf

RCO	
Date Added/ Revised	**Questions and Answers**
11/10/16	**Q309. Please provide clarification on the benefit for IV therapy and whether or not this would be considered a covered benefit through the RCO agreement. We have been contacted by several home IV therapy providers regarding contracting and when we looked these providers up in the Alabama Medicaid provider file, they are listed as "pharmacy" providers and not DME (which is where the infusion codes reside). We are clarifying that these provider types would be able to bill and be reimbursed for the S codes identified on the DME fee schedule (home infusion codes) and that we can identify these providers as a DME provider type (contract type) rather than pharmacy. In addition, please clarify if it is the expectation that the IV Therapy providers would have to split bill their services to the RCO and Medicaid in order to be reimbursed. For Example: Pharmacy to Medicaid, Home Health to Medicaid and the supplies to the RCO?** A309. If a pharmacy bills the IV drugs today to pharmacy (which is our understanding how most bill), the pharmacy would continue to bill the drugs through pharmacy in the RCO world, and these drugs would not be subject to the RCO oversight. However, the ancillary supplies (such as tubing, machines, needles, etc) are currently billed through DME, and this portion will be subject to RCO oversight, and these entities would need to enroll in their RCOs for this purpose. These pharmacies are currently (or should be) enrolled as both pharmacy and DME. Their DME NPI will be subject to the RCOs, the pharmacy NPI not.
11/10/16	**Q310. Can an RCO use one TTY line for all 5 regions if calls can be tracked and reported by region?** A310. An RCO may use one TTY line for all 5 regions provided the reporting and tracking requirements can be provided for each region.
11/10/16	**Q311. Do you maintain a list of AL 340b providers?** A311. A list of 340b providers may be queried by searching on "Alabama" on the HRSA 340b Database https://opanet.hrsa.gov/340B/Views/CoveredEntity/SearchDirectory
11/10/16	**Q312. With the new go-live of 7/1, has there been any discussion for information regarding HEDIS from the State Medicaid office? One specific question is HEDIS reporting in 2018- what are expectations in reporting for that year?** A312. Yes, you will have to report on the quality measures every year. If you are asking about the Withhold program, all of the updated language will be in the updated RCO Contract pending CMS approval.

RCO	
Date Added/ Revised	**Questions and Answers**
11/10/16	**Q313. Provider Manual Renal Dialysis Facility (Chapter 35 of Provider Manual) describes a monthly capitation payment to physicians providing outpatient services related to ESRD for patients dialyzing at home or in an ESRD facility. Please verify if CPT codes 90951-90966 are conclusively the codes included under this policy. What is the actual PMPM?** A313. Yes, per the Physicians Chapter 28, ESRD section 28.2.9 and Renal Dialysis Facility Chapter 35, the appropriate procedure code by age as outlined in the CPT is to be used. CPT code range 90951-90966 is covered for physician billing. Please visit the physician fee schedule at the following link: http://www.medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Physician_Fee_Schedule_10-1-16.pdf
11/10/16	**Q314. Has the RCO Membership Matrix been revised since the posted 1/28/16 draft? If so, please advise where I can obtain a current RCO Membership Matrix.** A314. No, the draft RCO Membership Matrix has not been revised. The current matrix can be found at the following link: http://medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Topics_Issues/2.7.3_RCOs/2.7.3_RCO_Membership_Matrix_1-28-16.pdf
11/10/16	**Q315. I thought all RCOs were on hold, but we were contacted by Alabama Community Care. Can you confirm status of RCOs for me?** A315. Pending CMS approval, the new RCO start date will be July 1st, 2017. Please visit the following link for more information: http://medicaid.alabama.gov/news_detail.aspx?ID=11768